# CHT Healthcare Trust - Onewa Hospital and Rest Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Onewa Hospital and Rest Home

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

**Dates of audit:** Start date: 29 October 2018 End date: 29 October 2018

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 60

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | 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 Onewa is owned and operated by the CHT Healthcare Trust. The service cares for up to 70 residents requiring rest home and hospital (geriatric and medical) level care. On the day of the audit, there were 60 residents in total.

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

A unit manager, who is well qualified and experienced for the role oversees the service and is supported by a clinical coordinator and area manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit identified two improvements required around documented interventions and self-medicating.

The service is commended for maintaining a continuous improvement rating around the reduction of falls.

## 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. |

Policies are implemented to support residents’ rights, communication and complaints management. Family are involved in the initial care planning, provided with ongoing feedback and informed if an incident/accident or a change in resident’s health status occurs. 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. |

CHT Onewa has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Aspects of quality information are reported to three monthly combined staff and quality meetings. Residents and relatives are provided with the opportunity to feedback on service delivery issues at two monthly resident/relative meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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. |

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are resident, and goal orientated and evaluated every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents at least three monthly. The activity coordinators implement the integrated activity programme in the rest home/hospital to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are entertainers, outings, and celebrations. The registered nurses and senior health care assistants administer medications and have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. All meals are cooked on site by a contracted service. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

## Safe and appropriate environment

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

CHT Onewa holds a current warrant of fitness. There is a reactive and planned maintenance programme in place.

## 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. |

CHT Onewa has restraint minimisation and safe practice policies and procedures in place. On the day of the audit the service had seven residents with eight restraints and one resident using an enabler. Staff receive training in restraint minimisation and challenging behaviour management.

## 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. |

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 | 14 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 1 | 38 | 0 | 0 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Care staff interviewed; five healthcare assistants (HCA), one registered nurse (RN) and one clinical coordinator were able to describe the process around reporting complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaints/compliments folder is maintained with all documentation. The unit manager is responsible for complaints management and advised that both verbal and written complaints are actively managed.There have been sixteen complaints received in 2017 and nine complaints for 2018 (year-to-date) as evidenced in the complaints/compliments folder. Response to complaints was recorded and included meetings with complainants, performance management of staff if appropriate and recording of resolution and outcomes. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to raise any concerns.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has an open disclosure policy. Discussions with three residents (one hospital and two rest home) and four relatives (all hospital) confirmed they were given time and explanation about services and procedures on admission. Resident/relative meetings occur every two months and the unit manager has an open-door policy. 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. Incidents/accidents forms reviewed include a section to record family notification. All ten incident/accident forms reviewed from September 2018 indicated that family had been informed. Relatives interviewed confirmed they were notified of any changes in their family member’s health status. Interpreter services can be accessed if needed. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | CHT Onewa is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital (geriatric and medical) level care for up to 70 residents. On the day of the audit there were 60 residents in total. Of the 70 beds, there are 67 dual-purpose beds (41 hospital including one double-room and 26 rest home) and three respite beds. There were 32 rest home residents, including one resident on respite care (under the age of 65) and one resident on interim care and 28 hospital level residents. All other residents are on the age-related residential care (ARRC) contract.Onewa is part of the CHT northern region and is led by a unit manager who is a registered nurse with a current practicing certificate. She has been in a management role at the facility for two years and has worked in the aged care industry for over 10 years. She is supported by a clinical coordinator who has been in the role for two and a half years. An area manager supports the management team and was present on the day of the audit. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Onewa has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The unit manager has completed in excess of eight hours of professional development in the past 12 months. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is an organisational business/strategic plan that includes quality goals and risk management plans for CHT Onewa. There is documented evidence that the quality system continues to be implemented at the service. Interviews with staff confirmed that quality data is discussed at the monthly quality/health and safety/staff meetings to which all staff are invited. 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. The service's policies are reviewed at national level with input from facility staff every two years. Data is collected in relation to a variety of quality activities and an internal audit schedule of core standards and infection control was completed in October 2018. All CHT data is entered into an electronic management system. Areas of non-compliance identified through quality activities are actioned for improvement. Resident satisfaction surveys are conducted monthly with a selection of residents. The surveys reviewed for 2018 year to date, indicated a high level of satisfaction. Resident/relative meetings are held every two months.All clinical and non-clinical staff at CHT Onewa are allocated to specific quality teams over a 12-month period. These teams are compiled of RNs, HCAs, physiotherapists, the chef, and activities coordinators as needed. Each team collects statistics each month and prepares a summary report that is shared with all staff at the monthly quality/health and safety/staff meeting. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety group took a proactive approach and undertook a root cause analysis of falls. Monthly reports to the quality team documented where and when falls were occurring, common themes for falls and identification of frequent fallers. Falls prevention strategies are implemented including identifying residents at higher risk of falling or needing closer observation, review of call bell response times, providing falls prevention training for staff and encouraging resident participation in the activities programme.  |
| Standard 1.2.4: Adverse Event 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.  | FA | There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly clinical and staff meetings including actions to minimise recurrence. Ten resident incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observations were completed for six unwitnessed falls reviewed with a potential injury to the head. Discussions with the unit manager and area manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification report was completed for an unstageable pressure injury in October 2017. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | 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. Five staff files were reviewed (one clinical coordinator, one RN, one activities coordinator and two HCAs). All files evidenced that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. 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, clinical coordinator and RNs are able to attend external training, including sessions provided by the local DHB. Seven of nine RNs have completed interRAI training.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 47 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs of different shifts. The unit manager and clinical coordinator work 40 hours per week and are available on call after-hours. There is at least one RN on duty at all times. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff, residents and relatives confirmed there are sufficient staff to meet the needs of residents. The service currently has 60 residents in total (32 rest home and 28 hospital residents). In the hospital unit (31 beds) there were seventeen hospital residents and seven rest home residents. There is a RN rostered on the morning, afternoon and night shifts who is supported by five HCAs on the morning shift (four long and one short shifts), four HCAs on the afternoon shift and two HCAs on at night. In the rest home unit (39 beds) there were 11 hospital residents and 25 rest home residents. There is a RN rostered on the morning, afternoon and night shifts who is supported by four HCAs on the morning shift (two long and two short shifts), three HCAS on the afternoon shift (two long and one short shifts) and two HCAs on at night. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely. Registered nurses and senior HCAs are responsible for medication administration and complete annual medication competencies and annual medication education provided by the pharmacist and the GNS. Registered nurses have completed syringe driver competencies through the hospice. Robotic medication rolls are checked on delivery by the RN on duty and the ‘date checked’ entered into the electronic medication system. There is an impress stock and bulk supply order (for hospital level residents) which is checked regularly for expiry dates. Eye drops were dated on opening. The medication fridges are checked daily, and temperatures were within acceptable ranges. There are no vaccines stored on-site. There were two residents self-medicating on the day of audit, however there was a shortfall around self-medication competencies. Ten medication charts on the electronic medication system were reviewed. All charts met prescribing requirements including the indication for use of ‘as required’ medications. The effectiveness of ‘as required’ medications had been entered into the electronic system. All charts had photo identification and allergy status identified.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals and baking are done on-site by a contracted service. The chef manager (interviewed) is responsible for the operations of the food services. The chef is supported by a weekend cook and kitchenhands. There is a food control plan that has been verified 6 April 2018. The four-week spring/summer menu has been reviewed by a dietitian. Meals are plated in the main kitchen and delivered in hot boxes to the dining rooms. Dietary requirements include vegetarian, pureed and mince/moist meals are provided. There is specialised crockery and cutlery for use as required. Dislikes are known and accommodated. Fortified foods (REAP) is provided for residents with identified weight loss and as instructed by the RN/dietitian. The temperatures of refrigerators, chillers, freezers and end cooked foods are monitored and recorded daily. All food is stored appropriately. A cleaning schedule is maintained. Residents have the opportunity to provide feedback at resident meetings and surveys. Residents interviewed were satisfied with the meals.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses and HCAs follow the care plan and report progress against the care plan each shift at handover. If a resident’s condition changes the RNs will initiate a GP or nurse specialist referral. Relatives interviewed confirmed they were notified of any resident health changes. Not all interventions had been implemented/documented to meet resident current needs in three files reviewed. Staff have access to sufficient medical supplies and dressings. Wound assessment, wound monitoring, and wound evaluations are in place for nine residents with current wounds including one facility acquired stage one pressure injury and one stage two pressure injury. There is sufficient pressure relieving equipment such as cushions and air alternating mattresses. Documentation and photos monitor healing progress. The wound nurse specialist can be accessed if required. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB. There was evidence of monitoring a resident’s health status such as change of position charts, food and fluid charts, regular monitoring of bowels, monthly weights, blood pressure, blood sugar levels, pain monitoring and behaviour, as required. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are two activity coordinators who are qualified diversional therapists (DT). One works Monday to Friday from 9.30 am – 4.30 pm and the other works four mornings a week, however both are flexible around outings and the movie night. There is one integrated activity programme which offers a choice of two activities on days where there are two DTs. There is a part-time activity coordinator on Saturdays. The programme identifies the activity time and location, and care staff assist residents to the activity of their choice. Activities include (but are not limited to); newspaper reading, a variety of exercises (sit-dancing, balloon tennis, Tai Chi), board games, sensory activities, movies, happy hour with entertainment, walks, crafts, bowls and hand care. There are a number of volunteers involved in the activity programme who spend one-on-one time with residents, singing, piano playing, pet therapy and the knitting group. One-on-one individual time is spent with residents who do not wish or are unable to participate in group activities. The service hires a mobility bus for its hospital/rest home resident outings to places of interest in the community. There are regular interdenominational church services and communion. A lifestyle questionnaire is completed soon after a resident’s admission. An individual activities plan is developed for each resident and is evaluated six monthly in consultation with the resident and RN. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys. Residents and relatives interviewed stated they were happy with activities offered.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans reviewed had been evaluated by the RNs within three weeks of admission. The long-term care plans have been evaluated in discussion with the resident/relative at least six monthly or earlier for health changes. The respite care resident and interim care resident were not required to have an evaluation of care. The six-monthly care plan evaluations involve care staff, applicable allied health professionals and the resident/relative. The six-monthly written evaluations for long-term residents record the resident’s progress against the resident goals and updated with any changes to care (link 1.3.6.1).  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 21 February 2019. There is a reactive and planned maintenance programme in place. Refurbishments are ongoing.  |
| Standard 3.5: SurveillanceSurveillance 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 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 the facility meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There has been one influenza outbreak since the previous audit, and documentation reviewed identified this was well managed. The infection control coordinator/RN oversees infection surveillance for the service. 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 standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the monthly management and clinical meetings. Results from laboratory tests are available monthly. There have been no outbreaks. The service has continued to maintain low overall infection rates. All infection rates have remained low over the past year. Staff continue to practice effective infection control practice including good hand hygiene, ongoing education, resident education and internal infection control audits. Surveillance for all infection types have remained below the CHT average, ranking Onewa first among the CHT group from October 2017 to October 2018. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the staff confirmed their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The service has eight restraints (four bedrails and four lapbelts) and one resident using an enabler (bedrail). An assessment for restraint use and consent form were evidenced in the resident file reviewed using an enabler. Staff have received training in restraint minimisation (August 2018) and challenging behaviour management (September 2018).  |

# 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 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There are policies and procedures in place that comply with self-administering of medications. There were two residents self-medicating on the day of audit. Self-medication competencies had not been commenced for one resident and not current for the other resident.  | i) The respite care resident admission assessment and short-term care plan (link 1.3.6.1), identified the resident was self-medicating. This was verified by care staff. There was no evidence of a self-medication competency in place and ii) the rest home resident self-medicating competency had not been reviewed three monthly.  | Ensure self-medicating residents have a current self-medication competency in place. 60 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Monitoring forms are used to record a resident’s progress which are reviewed by the RNs. The HCAs report any changes to residents’ health to the RN and document changes in the progress notes. Resident changes are discussed at shift handovers and changes made to care plans to guide HCAs in the safe delivery of care, however not all resident changes and interventions had been documented/implemented.  | i) The risks of using an enabler bedrail had not been documented in the care plan for one hospital resident, ii) there was no evidence the admission assessment and support plan had been reviewed at each admission for the respite care. There was no evidence of a weight record ,and iii) the resident on interim care did not have any documented interventions for known pressure injury risk, and pain. There was no evidence of monitoring around the colour, warmth, movement and sensation of a limb in a plaster cast.  | i) Ensure risks associated with enabler use are documented in the care plan, ii) ensure the support plan is reviewed at each respite care episode and there is a baseline weight documented and iii) ensure risks are identified and interventions documented for short-stay residents as applicable. 60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | All clinical and non-clinical staff at CHT Onewa are allocated to specific quality teams over a 12-month period. These teams are compiled of RNs, HCAs, physiotherapist, the chef, and activities coordinators as needed. Each team collects statistics each month and prepares a summary report that is shared with all staff at the RN meeting and monthly staff meeting. Training sessions are based on findings identified in these trend analysis reports. The teams include health and safety, infection control, restraint, the skin care and pressure injury team, the continence team, the REAP (weight management team).  | Data collated is used to identify any areas that require improvement. Since the previous audit, the service has continued to review strategies to minimise falls. Falls were again identified in October 2016 as an area that required improvement. The health and safety group took a proactive approach and undertook a root cause analysis of falls. Monthly reports to the quality team documented where and when falls were occurring, common themes for falls and identification of frequent fallers. Falls prevention strategies were implemented that included identifying residents at higher risk of falling or needing closer observation, review of call bell response times, providing falls prevention training for staff, ensuring adequate supervision of residents, encouraging resident participation in the activities programme and ensuring residents are part of the Vitamin D programme. Other initiatives included physiotherapy assessments for all residents, routine checks of all residents specific to each resident’s needs (intentional rounding), the use of sensor mats, night lights and increased staff awareness of residents who are at risk of falling. On evaluation of the effectiveness of these measures (which they undertake weekly), they noted a drop-in fall incidents. During 2017, the service averaged 18 falls per month, falling to an average of 12 falls per month during 2018 to the week ending 22 October 2018. The Health and safety team credit this reduction to a team approach that involves all aspects of staff from managers to HCAs and encompassing activities staff and RNs.  |

End of the report.