CHT Healthcare Trust - CHT Bernadette

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:

Legal entity:	CHT Healthcare Trust
Premises audited:	CHT Bernadette
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 January 2019 End date: 17 January 2019

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: 73

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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 Bernadette is owned and operated by the CHT Healthcare Trust and cares for up to 113 residents requiring rest home or hospital (geriatric and medical) level care. On the day of the audit, there were 73 residents. The service is overseen by a unit manager who is well qualified and experienced for the role and is supported by an acting clinical coordinator and the area manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

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

This audit has identified areas for improvement around: corrective actions; care plan interventions; hot water temperatures; and access to call bells.

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

The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

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

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff includes in-service and online education and training. Registered nursing cover is provided seven days a week, twenty-four hours a day.

Residents and families report that staffing levels are adequate to meet the needs of the residents. The integrated residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

There is a comprehensive admission package available prior to, or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Care plans are written in a way that enables all staff to clearly follow their instructions. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three-monthly or more frequently if needed.

The activities coordinator and staff implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families report satisfaction with the activities programme.

All meals are cooked on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility.

All bedrooms are single occupancy, and most have their own ensuites. There are adequate numbers of communal toilets and showers. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are communal lounges and dining rooms in each wing. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible.

Cleaning contractors and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of civil defence and other emergencies. Six-monthly fire drills are conducted.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The restraint coordinator is a registered nurse. The service had one resident assessed as requiring the use of restraint and one resident assessed as requiring an enabler. Staff regularly receive education and training in restraint minimisation and safe practice.

Infection prevention and control

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

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

Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	4	0	0	0
Criteria	0	97	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with sixteen staff (six healthcare assistants (three on the AM shift and three on the PM shift), four registered nurses (RNs), two activities coordinators, one cleaner, one cook and one maintenance) and one physiotherapist (external contractor) confirmed their familiarity with the Code and its application to their job role and responsibilities. Interviews with ten residents (five hospital level and five rest home level) and nine families (five rest home level and four hospital level (including one family of a resident on the young person with a disability (YPD) contract) confirmed that the services being provided are in line with the Code.
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	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Nine of nine resident files sampled (four from the rest home and five from the hospital) have a

		signed admission agreement and completed informed consent documentation.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services and staff receive regular training on advocacy. Information about accessing advocacy services information is available in the information presented to residents and families at the time of entry to the service. Advocacy contact details are included on complaint forms. Advocate support is available if requested. One complaint lodged in 2018 included input from the Health and Disability Advocacy service. Interviews with staff and residents confirmed that they are aware of the resident's right to advocacy services. HCAs interviewed confirmed that they help advocate for the residents.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents and family members interviewed confirmed that relative/family visiting could occur at any time. Community links were evident with examples provided. Residents (who are able) walk to the adjacent shopping mall and one resident (ACC) regularly attends a local gym.
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. There are complaints forms available at reception that provide links to HDC advocacy services. Information about complaints is provided on admission. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that is held by the unit manager. Verbal and written complaints are documented. All complaints reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. Results are fed back to complainants. Complaints are trended at head office. Of the complaints reviewed, one complaint was lodged with the HDC advocacy service (April 2018) with recommendations evidenced as implemented. No complaints were lodged with the HDC Commissioner since the previous audit although there was one lodged back in July 2015. This complaint has only recently been closed. The HDC Commissioner's office has made seven recommendations around communication tools; medication management; skin and wound management; staff training; and implementation of the Waterloo pressure injury risk assessment

		tool. These recommendations are being implemented. Discussions with residents and families confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Code on display and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The resident pack includes a summary of information relating to the Code and a pamphlet on the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Policies align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their privacy needs were met and that they were treated with dignity and respect. Staff receive regular training around recognising abuse and neglect (5 October 2018). There have been no reported incidents of abuse or neglect since the last audit.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan in place for the organisation. Māori links are established through the DHB and local Arataki community centre. No residents identified as Māori on the day of the audit. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	There is a policy that describes spiritual care. Monthly church services are conducted in the facility. Residents interviewed confirmed that their spiritual needs were being met. The service has established cultural policies aimed at helping meet the cultural needs of its residents. All

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including each resident's cultural beliefs and values, are used to help to develop a plan of care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct that staff sign as part of the employment process. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position and ethics.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that aligns with the Health and Disability Services Standards, for residents with aged care and residential disability needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by their unit manager. A GP in on-site twice a week. A podiatrist visits every six weeks and a physiotherapist is contracted to provide eight hours per week. All new residents and residents who have had a fall are assessed by the physiotherapist. Kitchen, cleaning and laundry services are outsourced.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. There is an interpreter policy in place and contact details of interpreters are available. 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. Ten incidents/accidents forms reviewed indicated family were informed. Family members interviewed confirmed that they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned,	FA	CHT Bernadette is owned and operated by the CHT Healthcare Trust. The service provides hospital and rest home level care for up to 113 residents. On the day of the audit, there were 73 residents. This included 39 rest home level residents and 34 hospital level residents. One resident (hospital level) was funded by ACC, one resident (hospital level) was on the young

coordinated, and appropriate to the needs of consumers.		person with a disability (YPD) contract and three residents were on the long-term service chronic health care (LTS-CHC) contract (two hospital and one rest home). All rooms that are currently being used on two levels are certified dual purpose. Eleven rest home only beds have been decommissioned. Renovations of the facility are underway. The organisation has a philosophy of care, which includes a mission statement. The unit manager is a registered nurse who was initially appointed as the clinical coordinator (March 2018). She has 20 years of experience in aged care. She became the acting unit coordinator in August 2018 and was promoted to unit manager in early December 2018. She maintains an annual practicing certificate. She completed a post graduate diploma in leadership and management in professional practice in 2018 and regularly attends monthly CHT management training in Auckland. The acting clinical coordinator is a registered nurse who was appointed to her role when the current unit manager accepted the acting unit manager role. She is trained in interRAI and regularly attends in-service training. Her medication competencies (including syringe driver) were up to date. The unit manager reports to the area manager weekly on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past 12 months.
Standard 1.2.2: Service Management 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.	FA	In the absence of the unit manager, the area manager is in charge with support from the acting clinical coordinator, care staff and head office.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The performance plan for the facility includes quality goals (strategic themes) with associated actions, milestones and dates achieved. The unit manager advised that she is responsible for providing oversight of the quality programme. Interviews with staff confirmed their familiarity with the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A

		document control system is in place. Policies are regularly reviewed and updated at the organisational level. New policies or changes to policy are communicated to staff in the staff meetings. A range of data (eg, falls, laundry incidents, property incidents, complaints, staff incidents, medication errors) are collected, collated and analysed at head office. Advised, these results are shared with staff. An internal audit programme consists of two six-monthly audits completed by the area manager (March and October 2018). There was evidence in the (three) staff meetings in 2018 to verify staff were informed of the internal audit results. Other audits include a monthly health and safety internal audit and resident satisfaction surveys are regularly sent to residents and family. Other internal audits include monthly restraint audits, weekly wound and skin audits and monthly health and safety inspections. The 2018 meeting minutes reviewed included only one clinical meeting in 2018 (April 2018) and three staff/quality meetings (April, July, October 2018). Interviews with staff confirmed that meeting minutes are not posted for them to read/review. Resident/family meetings take place on a quarterly basis. Although corrective actions were identified and signed off following the six-monthly internal audits, there were no documented corrective actions identified to address concerns reported in the resident satisfaction survey results, although management could describe these. A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (RN) and review of health and safety documentation confirmed that legislative requirements are being upheld. External contractors and all new staff have been orientated to the facility's health and safety programme. The hazard register was up to date and is regularly monitored by the health and safety officer. The facility is currently undergoing a building renovation. Hazardous barriers and orange cones are in place to prevent access to both hazards (eg, holes in the floor) and construction areas. Strategies are in place to reduce the number of residents' falls. All new residents and residents who have experienced a fall are assessed by a physiotherapist. Sensor (buzzer) mats are used for those residents who are at risk of falling. These residents are checked frequently and are encouraged to be out of their rooms during the day so that they can be monitored more closely.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by	FA	There is an accidents and incidents reporting policy that is being implemented by the service. Ten accident/incident forms were randomly selected for review. A registered nurse conducts clinical follow up of each adverse event. Neurological observations are conducted for unwitnessed falls. All adverse events reviewed demonstrated that appropriate clinical follow up

the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		and investigation took place. Adverse events are also reviewed and signed off by the unit manager. Trends are identified at head office with data benchmarked against the other CHT facilities. This data is available electronically for managers to access. Discussion with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided (eg police investigations, RN cover, pressure injuries).
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 that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Seven staff files (one acting clinical coordinator/RN, two staff RNs, three HCAs and one activities coordinator) reviewed evidenced implementation of the recruitment process, employment contracts and annual performance appraisals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and remarked that new staff were adequately orientated to the service. Evidence of an orientation programme being completed was sighted in the staff files reviewed of staff who had been hired by CHT. There is an annual education plan that is being implemented that includes in-services and completion of online education modules. The competency programme is ongoing with different requirements according to work type. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Seven of the eight registered nurses employed have completed interRAI training. The unit manager completed a post graduate certification in 'leadership and management in professional practice' in 2018.' She attends monthly CHT manager's meetings in Auckland that cover professional development relating to managing an aged care service. In addition, she attends in-service training at the facility (eg, chemical safety, syringe driving training, restraint minimisation, cultural training, infection control training, food safety training). The acting clinical coordinator has maintained training records that reflect attendance at the following in-services in 2018: informed consent; abuse and neglect; cultural safety; medication management; death and dying; infection control; clinical emergencies/CPR; continence management; restraint minimisation; skin and wound management; health and safety; chemical handling; and accident/incident reporting.

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. There were 73 residents at the facility during the audit that are spread across 3 wings (Hospital wing (downstairs): 23 residents (13 hospital, 10 rest home); Matakana downstairs: 25 residents (19 rest home, 6 hospital), Matakana upstairs: 25 residents (8 rest home, 17 hospital). Sufficient staff are rostered on to manage the care requirements of the residents. Agency staff are used when casual staff are not available. The unit manager remarked that RN staffing turnover has been moderate with losses reported in 2018 to the DHB. The unit manager and clinical coordinator support the RNs Monday – Friday. Two RNs (one upstairs and one downstairs) cover the AM and PM shifts and one RN covers the night shifts. Two long and one short shift HCA cover each wing on the AM shift. For the PM shift, one long shift and one short shift covers each downstairs wing and the upstairs wing is staffed with two long shift and one short shift HCA. Nights are staffed with three HCA's, one on each wing. Note: during this two-day audit, the agency RN for the night shift did not arrive and the unit manager/RN slept over at the facility. A section 31 was completed. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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 are not able to view sensitive resident information. Entries in records are legible, dated and signed by the relevant HCA or RN.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The unit manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the unit manager and clinical coordinator. The admission agreement form in use aligns with the requirements of the contracts. Exclusions from the service are included in the admission agreement. The

		information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs using the yellow envelope system. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
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.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. The facility uses a four-week robotic sachets system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and senior medication competent healthcare assistants administer medications. Medication competencies are updated annually, and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened. Registered nurses use an electronic medication management system and sign for the administration of medications. Eighteen medication charts were reviewed. Medications have been reviewed at least three-monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a fully functional kitchen and all food is cooked on-site by contracted kitchen staff. A food control plan has been verified and expires in April 2019. There is a food-services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian in September 2018. 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.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All relevant personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments and relevant risk assessment tools were completed on admission and risk assessments were reviewed at least six-monthly or when there was a change to a resident's health condition in files sampled. The care plans are developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Overall long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process as evident. Short-term care plans were available for acute changes, however, RN's interviewed advised in most situations the long-term care plan (LTCP) is updated for acute changes. Changes and updates for changes in health status were evident in the LTCP in the files reviewed, however not all required interventions were documented. There was evidence of service integration with documented input from a range of specialist care professionals. Staff interviewed reported the care plans provided guidance for resident care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired	FA	Registered nurses (RNs) (including the clinical coordinator) and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound nurse specialist). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files

outcomes.		include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place for 23 wounds, including 1 stage II pressure area (facility acquired). All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the wound nurse specialist. A full skin check of all residents at risk of pressure injury is completed weekly by the RN. Interviews with registered nurses, the acting clinical coordinator and healthcare assistants demonstrated an understanding of the individualised needs of residents. Food and fluid charts are comprehensively completed as required. Care plan interventions and food and fluid charts demonstrate interventions to meet residents' needs (link 1.3.5.2).
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Three activities coordinators are employed, each working between 18 and 28 hours per week and covering 7 days a week. The activities team provide a varied activities programme designed to meet the needs of all residents. Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed as part of the care plan by the registered nurses, with input from the activities staff. Residents are free to choose whether to participate in the group activities programme or their individual plan and participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have an activity plan within the care plan and this is evaluated at least six-monthly when the care plan is evaluated. The activities programme includes activities suitable for younger residents. Residents and families interviewed commented the regular activity programme provides an interesting and varied programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. There is at least a three-monthly review by the GP. An RN signs care plan reviews. Files evidenced that changes had been initiated to the care plan in response to changes in health needs or where progress was different from expected (link 1.3.5.2). Changes in short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Staff advise that in most cases, changes are made directly to the long-

		term care plan and reviewed six-monthly or sooner when required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. Staff provided examples of where a resident's condition had changed, and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are 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 sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The service displays a current building warrant of fitness. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment has been recently serviced and/or calibrated. Hot water temperatures are monitored, however not all temperatures in resident areas have been documented at 45 degrees Celsius or below. The service implemented a corrective action plan on the day of audit. This included checking all temperatures in all rooms and a plumber had been contacted to assist. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities.	FA	Bedrooms in the newer part of the building all have ensuites. Bedrooms in the older part of the building all have a hand basin and some have toilets. There are an adequate number of communal toilets and shower/bathing areas for residents. All communal toilets and shower rooms have vacant/engaged slide signs. Residents interviewed confirmed their privacy is

Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The communal areas include a large open-plan lounge and smaller seating areas. Activities take place in a number of areas throughout the facility. There are two dining rooms. Communal rooms are easily accessible.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Contracted cleaning staff clean the facility. 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. All laundry is done off-site and is collected and delivered daily. All personal clothing is clearly labelled at the facility and transported to the external laundry in individual mesh bags. Residents and relatives interviewed advised that they were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	The fire evacuation plan has been approved by the fire service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking. There is short-term back up power for emergency lighting and the call bell system is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available

		at all times. There are call bells in the residents' rooms, and lounge/dining room areas. The Austco call bell system is audited regularly by maintenance staff. Interviews with residents confirmed that call bells are answered in a timely manner but are not consistently within reach of the residents. The building is secure after hours and there are night time security rounds.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.
Standard 3.1: Infection control 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.	FA	CHT Bernadette has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and staff involved in the infection control meetings that is linked to clinical meetings. Spot 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 Bernadette 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 has good external support from the local laboratory, an external contractor, infection control team and IC nurse specialist at the DHB and CHT head office. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol handgel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of	FA	There are CHT infection control policies and procedures appropriate for the size and complexity of the service. Policies are available electronically on file vision or in hard copy. The infection control manual outlines a comprehensive range of policies, standards and guidelines and

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.		includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. 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 external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered into an electronic resident system and extracts provide a monthly infection summary. This data is monitored, evaluated and reported monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There was one resident with restraint and one resident with an enabler. Enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Staff interviews and staff records evidence that guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality/health and safety meetings.

Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The acting clinical coordinator is the designated restraint coordinator. Assessment and approval processes for restraint use include the restraint coordinator, registered nurses, resident and/or EPOA/family and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes a comprehensive assessment for each resident who requires restraint or enabler interventions that meets criteria (a) – (h). Assessments are undertaken by either the restraint coordinator or a staff registered nurse in partnership with the family/whānau and medical practitioner (evidenced in one resident file where a restraint was being used (hospital level) and in one resident file where an enabler was being used (hospital level). In both files reviewed, consents for the use of the restraint/enabler were also completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraints are put in place only where it is clinically indicated, justified and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms document regular monitoring at the frequency determined by the risk level, which in the case of the one resident using a restraint was four-hourly. The service has a restraint and enablers register, which is updated each month. Restraint use is audited in the six-monthly internal audit. The completion of restraint forms (eg, assessments, monitoring forms, six-monthly reviews) are monitored a minimum of monthly by the restraint coordinator.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service evaluates the use of each restraint or an enabler every six months. In the two files reviewed (one restraint and one enabler), evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed every month by the restraint coordinator with data shared at the

		staff/quality and RN meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit programme and reporting cycle. The restraint minimisation programme is reviewed annually at head office with input provided by each CHT facility including Bernadette. Review processes include policy and procedures review, trends analysis around restraint use and the review of staff education programmes.

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed	PA Low	Corrective action plans were documented following each six-monthly internal audit with sign-off by the unit manager when achieved. Missing was evidence to reflect corrective action plans to address dissatisfied residents as indicated on resident satisfaction surveys.	The resident satisfaction survey results were collated during the audit. Seven of twenty-nine resident satisfaction survey results indicated that residents were dissatisfied. Seven residents rated the food as poor, two residents rated laundry as poor, two rated the building maintenance as poor, three would not recommend the facility to others, and three rated activities as poor. No corrective action plans were sighted to address these issues.	Ensure corrective action plans are developed where negative trends are identified. 90 days

and implemented.				
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Overall long-term care plans described the support and interventions required to meet the resident's goals. Staff could describe the care required. Acute changes in care are documented in either the long-term care plan or STCP. Dietary requirements identified by a dietitian had not been included in two care plans reviewed, however staff were implementing the required dietitian instructions and therefore the risk has been identified as low.	Care plans had not been updated for two residents with changes in dietary requirements as per dietitian instructions.	Ensure care plans include interventions to support all allied health instructions. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Hot water temperatures are recorded from a sample of resident rooms monthly. Over the last six months there were records recorded above 45 degrees with no follow up corrective action.	Records reviewed over the last six months identified hot water temperatures documented at 45 degrees and above. The service implemented a corrective action plan on the day of audit.	Ensure all hot water temperatures in resident areas are maintained at temperatures of 45 degrees or below 60 days
Criterion 1.4.7.5	PA Low	An electronic call bell system is in place that is regularly checked by maintenance staff. Residents did not	During a walk-through of facility over two days, it was observed that a selection of residents did not have access to their call bell. The HCAs responded by stating that they do not have enough	Ensure that all residents have access

An appropriate 'call system' is available to summon assistance when required.		have consistent access to their call bell during the audit.	long cords to reach from the beds to where the residents are sitting (note: the unit manager reported that they do have enough long cords). The acting clinical manager stated that if a resident is not considered by staff as competent to use their call bell, they are not given one. The unit manager confirmed that this has been an issue that she is working on addressing. One complaint lodged in February 2018 reported that a resident was unable to reach his call bell to call for help and had to rely on his neighbouring resident to ring his call bell for him	to a call bell to summon assistance if needed. 30 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.

No data to display

End of the report.