

CHT Healthcare Trust - Carnarvon Private Hospital

Introduction

This report records the results of a Certification Audit; Partial Provisional 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:	Carnarvon Private Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 September 2020 End date: 22 September 2020
Proposed changes to current services (if any):	This audit included verifying the final stage three of the new build, which is a modern, spacious, purpose-built facility with 18 dual-purpose beds, a lounge, hairdresser, and storage areas. Total capacity is at 60 dual-purpose beds following verification.
Total beds occupied across all premises included in the audit on the first day of the audit:	39



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

General overview of the audit

CHT Healthcare Trust - Carnarvon Private Hospital provides care for residents requiring rest home and hospital (medical and geriatric) level care. The service has completed the final part three of a new build with a total now of 60 dual purpose beds.

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, general practitioner, staff, and management.

In addition to the certification audit, a partial provisional audit was conducted to assess the preparedness of the service to provide dual purpose (rest home and hospital) level of care for 18 beds in a new wing. This audit has verified the service as being suitable to provide rest home/hospital level care in any of the 18 dual purpose beds reviewed.

The unit manager is experienced and is supported by the clinical coordinator and the area manager.

The audit identified improvements around interventions documented in the care plans, and in relation to completion of the new wing (stage three).

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Care is provided in a way that ensures residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Family are involved in the initial care planning and provided with ongoing feedback.

Regular contact is maintained with family, including if an incident/accident or a change in resident's health status occurs. Information on informed consent is included in the admission agreement and is discussed with residents and relatives. The service has documented complaints and there is evidence of follow-up. The complaints register reviewed, included verbal and written complaints and all sighted complaints are well managed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Carnarvon has a current business plan and a documented quality assurance and risk management programme that outlines objectives for the next year. The quality process includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Residents and relatives are provided with the opportunity to feedback on service delivery issues at monthly resident 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. Carnarvon has job descriptions for all positions that include the role and responsibilities of the position. Staff are supported to undertake external training. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members reported staffing levels are sufficient to meet resident needs.

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.
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Residents' records reviewed provided evidence that the registered nurses utilise the interRAI assessment and paper-based assessments as needed to assess, plan, and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioner and nurse practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The electronic medication charts are reviewed at least three-monthly by the general practitioner or nurse practitioner. The new beds will use the existing medication room.

An activities programme is implemented that meets the needs of the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, and cognitive abilities and preferences for each consumer group.

There is a large and well-appointed kitchen for the service. The menu is designed and reviewed by a registered dietitian at an organisational level. Food is delivered and transported as currently occurs, in a hot box to the unit kitchenettes and this will be the

process for the new beds in the new wing. Nutritional profiles are completed on admission and provided to the kitchen staff. An external provider is contracted to provide food services.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building holds a current warrant of fitness and a CPU for a recently completed stage two build. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

All resident rooms in the stage three build have an ensuite and there are adequate numbers of toilets, which are easily accessible from communal areas. Stage three also includes a hairdresser and storage rooms. Fixtures, fittings and floor and wall surfaces sighted in bathrooms and toilets are made of accepted materials for this environment. Resident rooms are of sufficient space to ensure care and support to all residents and for the safe use of mobility aids. Communal areas are well designed and spacious and allow for activities.

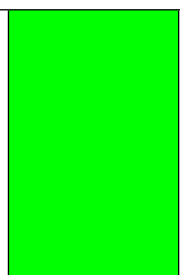
The fire evacuation plan is in the process of being approved by the New Zealand Fire Service.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There is a restraint register and a register for enablers. One resident used a restraint and three residents used enablers. Staff are trained in restraint minimisation and challenging behaviour management. Processes are implemented around assessment, monitoring and evaluation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other CHT facilities. There have been no outbreaks.

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	47	0	3	0	0	0
Criteria	0	96	0	5	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (seven healthcare assistants (HCAs), one registered nurse (RN), the clinical coordinator (CC), the diversional therapist, one area manager, unit manager, one property manager, cook, cleaner, maintenance, staff) confirmed their familiarity with the Code. Interviews with 10 residents (eight using hospital level of care with two identified as young people with a disability, and two residents using rest home level of care) and four family members (all with residents using hospital level of care including one family member who was a young person with a disability) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Seven resident files reviewed (five hospital including one ACC and one young person with a disability), and two files for residents using rest home services demonstrated that advanced directives are signed for separately. The healthcare assistants (HCAs) and registered nurse (RN) interviewed, confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All</p>

give informed consent.		resident files reviewed had a signed admission agreement.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff, residents and relatives informed they are aware of advocacy and how to access an advocate.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents are encouraged to be involved in community activities and maintain family and friend's networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and relatives confirmed this and that visiting could occur at any time. Family were sighted on the days of audit visiting their family members.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There is a complaint's form available. Information about the complaints process is provided on admission. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register. Three complaints received in 2020 were reviewed. The complaint had noted investigation, timelines, corrective actions, and resolutions including a meeting with the complainants and a follow-up written response documented. Discussions with residents and relatives confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer. 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 EPOA to read with the resident and discuss. On entry to the service a registered nurse, the clinical coordinator (CC), or the unit manager discusses the information pack with the resident and the family/whānau.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies, which 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 needs were met.</p> <p>There is a policy that describes spiritual care. Church services are conducted in the facility fortnightly. Because of the Covid pandemic, the minister has not been able to visit and a resident who has been a chaplain has offered services. All residents and relatives interviewed indicated that residents' spiritual needs are being met when required.</p> <p>Staff interviewed described appropriate processes to reduce the risk of abuse and neglect, and to identify and report this if it were suspected. There have not been any incidents related to abuse or neglect in the past year. The GP praised the service for the way services were delivered and stated that there was no evidence of abuse or neglect.</p> <p>Residents and family interviewed confirmed that they were encouraged to be independent as possible.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Staff training includes cultural safety. The service is able to access Māori advisors as identified in the Māori health plan and policies.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.</p> <p>There are staff on site who speak te reo Māori and residents who identify as Māori stated that they can engage with these staff. One resident interviewed who identifies as Māori stated that they really enjoyed being in the service and would encourage more Māori to come in for care and support. Clinical records for two residents who identify as Māori did not document reference to a cultural assessment or interventions (link 1.3.6.1). Family are encouraged to visit. Kaumātua from Waitemata DHB visit regularly to support Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	<p>FA</p>	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed, reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment should include a cultural assessment that includes the</p>

<p>services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>resident's cultural beliefs and values with needs identified then documented in the care plan. Residents and family interviewed confirmed that their cultural values were discussed at varying intervals. The staff come from a variety of cultural backgrounds, which are reflective of the residents and assists in meeting resident cultural needs.</p> <p>One resident interviewed who identifies as Māori stated that they really enjoyed being in the service and would encourage more Māori to come in for care and support. The record for this resident did not show any reference to cultural needs, activities, or links. A record for one other Māori resident was reviewed and again this did not identify cultural wishes in the assessment or show any cultural needs and interventions in the care plan (link 1.3.6.1). Both identify strongly as Māori.</p> <p>Three resident records were reviewed for residents identifying as Pacific and Indian. One of the three records had one need identified in the assessment, however this did not reflect in the care plan. The care plan did identify some brief interventions. The resident records for the other two residents did not reflect their links, needs, interventions to keep them connected to their communities or specific activities they liked to engage in (link 1.3.6.1). One resident was interviewed and stated that they enjoyed the service and found that family kept their links to their Pacific communities</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect process covers harassment and exploitation. All residents interviewed reported that the staff respected them.</p> <p>Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. There is a signed code of conduct in each staff file reviewed.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards to meet the needs of residents requiring hospital level of care. Staffing policies include pre-employment and the requirement to attend orientation and an ongoing in-service training plan. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p>

		<p>The service has a particular expertise in the care, support and management of people who require full support for activities of daily living. This includes support for residents with such illnesses as multiple sclerosis or stroke. Evidence was provided of residents referred for long-term care who were not expected to further improve when discharged from district health board (DHB) service but who had been rehabilitated at Carnarvon, to a point where they were mobilising better, engaged in activities and more independence. Residents interviewed were also able to confirm this. The unit manager and CC meet every Tuesday and Friday to review process and address any areas of concern. Over the past year CHT Carnarvon staff have worked hard to reduce the number of restraints used. Staff have worked closely with the physiotherapist to reduce the number of residents using restraint from five to one.</p> <p>The unit manager and staff have worked closely with residents, their families, and staff to reduce the stress of the Level 4 lockdown due to Covid 19. This was achieved by enabling all residents to connect twice weekly with their families via Zoom and regular newsletters sent out to families to keep them updated. Church services continued throughout the lockdown even though the minister was unable to visit. This was achieved by the staff and residents collaborating to devise their own services. The diversional therapist made use of YouTube to provide interesting Hymns and scenes. Evidence to support the effectiveness of this was the increase in number of residents attending and a request to have twice weekly services.</p> <p>In 2018 CHT implemented a QlikSense system, a tool for surveillance and gathering data. It sets the benchmark for analysing reports. The unit manager stated that this has helped managers in the organisation to make better decisions daily. It is effective and convenient for both operational and clinical monthly reports, trends, and analysis. This is embedded into the service.</p> <p>The GP praised the excellent service provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Sixteen incident/accident forms were sampled. The form includes a section to record family notification. All forms indicated family were informed. Relatives interviewed, confirmed they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>Carnarvon has been owned and operated by the CHT Healthcare Trust since November 2016. The service provides hospital and rest home level care for up to 42 residents. On the day of the</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>audit there were 39 residents. This included 35 residents requiring hospital level of care (including three young people with disabilities at hospital level and one young person with disabilities funded by ACC) and four at rest home level of care.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. The unit manager has significant experience in DHB aged care services and management of the service since 2016. Support for clinical leadership is provided by the clinical coordinator and competent registered nurses. The unit manager reports to the CHT area manager weekly on a variety of operational issues.</p> <p>CHT has an overall business/strategic plan and Carnarvon Hospital 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 more than eight hours of professional development in the past 12 months.</p> <p>Partial provisional: This audit also included verifying the final stage three of the new build, which is a modern, spacious, purpose-built facility with 18 dual-purpose beds, a lounge, hairdresser, and storage areas. Total capacity is at 60 dual purpose beds following verification. The current business plan includes goals and actions to transition to providing care in the new 18 bed wing.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the unit manager, the area manager is in charge, with support from the senior management team, including the clinical coordinator and the registered nurses. The clinical coordinator has been in the role for a year and a section 31 has been provided to the Ministry of Health. There will be no change to the area and unit managers or clinical coordinator when residents move to the new building and resident numbers increase.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans for CHT Carnarvon. There is evidence that the CHT quality system is being implemented at the service. The unit manager advised that they are 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 suitable for both hospital and rest home level care and are reviewed at national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals.</p> <p>Resident/relative meetings are held regularly, and previous issues raised are addressed at the beginning of each meeting.</p>

		<p>Data is collected in relation to a variety of quality activities and a comprehensive internal audit has been implemented. The QlikSense system is used as a tool for surveillance and gathering of data with the system linked to the patient management system – VCare. Data is collected around operational and clinical areas of the business including accidents, incidents, complaints, infections, restraint use, and feedback on the customer experience. QlikSense benchmarking reports are provided quarterly and the results discussed at the quality health and safety meetings monthly. The results of the customer experience survey showed that residents were very satisfied with care provided.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The unit manager is the designated health and safety person and health and safety issues along with one other health and safety representative. Issues and concerns are addressed in the monthly quality/health and safety meetings. These are also discussed at the monthly staff meetings. Meetings have been less frequent over the Covid lockdown periods, however, there has been at least one meeting a month to continue discussions around all aspects of the quality and risk management programme and changes related to Covid.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at the monthly quality/health and safety meetings. Sixteen incident forms were sampled, and all showed documented clinical follow-up of residents by the unit manager. Neurological observations were completed for a 24-hour period for incidents where residents had unwitnessed falls or where a resident had hit their head.</p> <p>Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There were no incidents required to be reported to external agencies since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>There are human resource management policies in place, which include 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. Six staff files were reviewed (two registered nurses, two healthcare assistants, the diversional therapist, and clinical coordinator) and evidenced that an application and reference checks are completed before</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>employment is offered. Criminal vetting is completed for all staff and each signs copies of key information technology policies and Code of Conduct. Performance appraisals and medication competencies are completed annually.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. A new staff member interviewed reported that there was a comprehensive orientation programme that included review of policies and a buddy system for a week that included working alongside an experienced HCA.</p> <p>The unit manager, registered nurses and healthcare assistants are able to attend external training including sessions provided by the local DHB. Four RNs including the clinical coordinator are interRAI trained. Staff complete training online through an external provider and the unit manager or clinical coordinator follow up with the staff member if extra support is required.</p> <p>Partial provisional: Staff employed have the skills to support rest home and hospital level residents. There are sufficient staff already employed as full time or casual staff to staff the new 18 bed wing and they have all completed relevant training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The unit manager (a registered nurse) is on duty from Monday to Friday and on call. At least one registered nurse is rostered on at any one time and all registered nurses have a current first aid certificate. Advised that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identified that staffing is sufficient to meet the needs of residents.</p> <p>Staffing (care staff) at the time of the audit (for 30 hospital level residents) was:</p> <p>Morning shift: Seven healthcare assistants (four long shift and three on a short shift).</p> <p>Afternoon shift: Four healthcare assistants including one on a short shift.</p> <p>Night shift: One registered nurse and two healthcare assistants.</p> <p>Partial provisional: A second roster is drafted with staffing defined for the whole facility including the new wing. The roster will then include:</p> <p>Morning shift: Eleven healthcare assistants (including three on a short shift).</p> <p>Afternoon shift: Six healthcare assistants including one on a short shift.</p> <p>Night shift: One registered nurse and four healthcare assistants.</p> <p>An extra registered nurse will be rostered onto the afternoon shift when the new wing has residents</p>

		in beds. The current staffing is sufficient to meet the needs of rest home and hospital level residents. Residents and family interviewed confirmed that there were sufficient staff on duty at any given time.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission.</p> <p>Other residents or members of the public cannot view sensitive resident information.</p> <p>Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the DT. Medication records are stored separately and securely.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are CHT admission policies which have been fully implemented by the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The unit manager and/or clinical coordinator screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. Upon admission, the residents are assessed by the receiving registered nurse.</p> <p>An information pack including all relevant aspects of the service, advocacy and health and disability information is given to residents/families/whānau at entry. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not included in the agreement. There were no short-stay residents at the time of audit.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>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. Relatives are notified if transfers occur.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented on the electronic system. All medicines are stored securely in the centrally located medication room when not in use. The medication room was observed to be very clean, and organised.</p> <p>A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Fourteen medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. There were no residents self-administering medicines. No vaccines are stored at the facility, fridge and room temperature are recorded and satisfactory.</p> <p>Partial Provisional: The medications for the new beds will be stored and managed from the existing centrally located medication room. The service has ordered an additional medication trolley.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food is cooked on site by contracted kitchen staff and transported to the various dining areas in scan boxes. 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. The kitchen meets the needs of residents who require special diets.</p> <p>Kitchen staff have completed food safety and chemical safety training. The kitchen manager and cooks follow a menu, which has been reviewed by the contracted company's dietitian. The cook (interviewed) was able to describe alternative meals offered for residents with dislikes and food is fortified for residents with weight loss. 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 happy with the quality and variety of food served. There is an approved food service plan which expires June 2021.</p> <p>The kitchen is large and spacious.</p> <p>Partial Provisional: The kitchen manager stated that the kitchen and staff can easily provide meals for the additional residents. An additional scan box has been purchased to transport meals to the</p>

		new wing dining area.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files sampled demonstrated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed, and the outcomes of assessments were reflected in the long-term care plans in resident files reviewed. The interRAI assessment tool has been completed for all residents. The interRAI assessments are completed six monthly or earlier if there are changes to the resident's health status.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The electronic care planning system is comprehensive and includes all aspects of care. The resident files were integrated, and care plans included input/guidelines from allied health providers. The service documents the care plans electronically and prints out the care plans. Printed care plans included writing updates as needed. Seven care plans were reviewed, and resident care interventions had been documented as needed, some care plans did not document the risks of medication used (link 1.3.6.1). Residents and relatives confirmed they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Care staff interviewed reported the care plans are readily available and they found the plans easy to follow. HCAs reported that handovers were comprehensive and that they are aware of resident needs.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired</p>	PA Low	Registered nurses (RNs) and HCAs follow the care plan and report progress at each shift handover. The care plans reviewed did not always include the risks associated with some medications or recognition of side effects. If external allied health requests or referrals are required, the RN or clinical coordinator initiates the referral (eg, wound care specialist, dietitian, or mental health team). The GP interviewed on day of audit spoke highly of the service and

<p>outcomes.</p>		<p>confirmed of being kept informed of changes in resident condition. Relatives agreed that the clinical care is good and that they are involved in the care planning.</p> <p>There were nine wounds on the day of the audit, including one facility-acquired stage one pressure injury. The pressure injury was linked to the quality system with a VCare incident form. The wound care file also included a schedule for indwelling catheter changes and catheter care checks. These were documented as being up-to-date.</p> <p>Wound assessment, wound management and evaluation forms were not in place for all wounds, and not all evaluations were compliant with service policies. Two wounds documented wound specialist input, and the recommendations from the wound specialist had been incorporated into the wound care plan. Wounds (other than minor skin tears) included photographs.</p> <p>There is specialist continence advice as required. Continence assessments have been completed at least six monthly, and adequate supplies were sighted. An education session has been held around continence and the HCA interviewed were knowledgeable around the use and types of products available.</p> <p>Interviews with registered nurses and HCAs demonstrated understanding of the individualised needs of residents. Regular weight monitoring, turning charts and intake and fluid balance charts in use were documented, one resident did not have blood sugar monitoring documented as often as required. Pain monitoring was documented as needed and one resident with oxygen therapy was being monitored as needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs an activities coordinator who is a qualified diversional therapist. The activities coordinator delivers the activities programme five days a week. The activities provided meet the recreational preferences and abilities of the resident groups and include arts and crafts, exercises, walks, board games, a weekly take-away, gardening club and happy hour. Activities reflect ordinary patterns of life and include planned visits to the community. Activities are held in the lounges. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. The service has created a male orientated 'games room' for which a pool table has been ordered. The activities are suitable for the younger residents.</p> <p>Each resident has an individual activities assessment on admission. An individual activities plan is developed for each resident in consultation with the resident/family. All long-term resident files sampled have a recent activity plan within the care plan and this is reviewed at least six-monthly when the care plan is evaluated, or a further interRAI assessment occurs. Residents interviewed commented positively on the activity programme.</p> <p>The service is in the process of employing an additional activities person to assist with the</p>

		recreation programme when resident numbers increase.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status, using the electronic care planning system. Care plan evaluations are documented and include reporting progress on meeting goals. All changes in health status are documented and followed up. Six monthly reassessments have been completed by RNs using interRAI for all residents and for those who have had a significant change in health status. 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. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services such as dietitian, and mental health for older persons. Referral documentation is maintained on resident files. The RNs 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 medical notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are documented processes for waste management. The policies document procedures for the safe and appropriate storage, management, use and control and disposal of waste and hazardous substances.</p> <p>All staff have completed training regarding the management of waste during induction with this sighted as being completed in staff files reviewed. Chemical safety training is a component of the training and orientation training and this will continue when staff move into the new building. Waste management audits continue to be a part of the internal audit programme.</p> <p>Gloves, aprons, and goggles are available, with staff sighted as using these appropriately. There are material safety data (MSD) sheets available.</p> <p>Partial Provisional: The new wing will access the existing (new) sluice in the stage two development.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The existing building has a current building warrant of fitness with an expiry date of 15 December 2020 and a CPU for the stage two new wing July 2020.</p> <p>The maintenance person covers four sites and is on site one day a week. The on call is shared with the building manager. Staff log any items for maintenance and repair into a maintenance book at reception. The maintenance book viewed demonstrated maintenance and repairs are addressed within a timely manner. Any urgent concerns can be emailed or phoned to the maintenance person. There are contractors available 24 hours for essential services.</p> <p>All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to safely designed external areas that have shade.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>Partial provisional:</p> <p>The new wing verified as part of this audit (stage three) is connected by a short corridor currently closed off due to building works. The new wing of 18 beds, a lounge, a hair stylist room, and storage cupboards is partially completed. The new wing will deliver 10 beds for Henderson wing, six beds for Waitakere wing (making this wing up to ten beds) and two beds for Opanku wing (bringing this wing up to ten beds).</p> <p>The new wing is the final process for the services refurbishment (stage three). All areas of the new wing will be of the same standard and will have similar fittings as the existing new areas.</p> <p>The building is on a flat section. The main driveway and parking area are completed, and all residents can access the community for shopping etc via a pathway that runs parallel to the driveway. Landscaping including gardens and courtyards have been completed.</p> <p>The property manager for the build confirmed that the building and plant have been built to comply with legislation. The organisation has purchased some new equipment for the service with other equipment being moved in with residents. Equipment is appropriate for hospital, rest home level of care. All equipment has been tested, tagged, and calibrated within the last year. Equipment and medical equipment calibration and servicing is captured within the quality programme and scheduled annually.</p> <p>Policies relating to provision of equipment, furniture and amenities are documented.</p>
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<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of toilets and showers with access to a hand basin and paper towels for residents and separate toilet areas for staff and visitors in the existing occupied areas.</p> <p>Every resident's room in the new building has an ensuite with a mobility aid friendly shower, toilet, and hand basin. Handrails have been installed. Equipment has been put in place.</p> <p>Partial provisional:</p> <p>All new rooms will have an ensuite. There is also a communal toilet. The area is not yet complete (link 1.4.2.1).</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms have been built as dual-purpose rooms (hospital/rest home care able to be provided) with each having an ensuite. Doors are wide to allow for furniture to be moved in an out and there is sufficient space to allow for a bed, lazy boy style chair, built in wardrobe and chest of drawers with room to take mobility aids and staff who would be supporting the resident. Mobility aids can be managed in ensuites as observed on the day of audit.</p> <p>Partial provisional:</p> <p>All new rooms are the same standard as existing rooms for the service. Equipment is yet to be installed (link 1.4.2.4).</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each of the current wings have a lounge and dining area that are easily accessible to all residents. There are courtyards which have been designed so that residents in their bed can also be transferred (in the bed) to the courtyards. There are shady areas under the roof eaves and under trees in the summer.</p> <p>Partial Provisional:</p> <p>There is a spacious lounge/dining room when the new build is completed that will be accessible by residents. The lounge will have a kitchenette and residents and family will be encouraged to use these. The open plan lounge/dining area is large enough for individual or group activities. Communal areas for entertainment, recreation and dining are in the process of being completed (link 1.4.2.1).</p>
<p>Standard 1.4.6: Cleaning And Laundry</p>	FA	<p>The organisation outsources housekeeping and laundry services. Clean linen is brought back and put in linen cupboards directly. There are wide hallways on each level with covered laundry bins in</p>

<p>Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>use to collect and transport dirty linen. Policies and procedures ensure all cleaning and laundry services are maintained and functional at all times.</p> <p>The cleaning manual includes instructions for cleaning. The service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits continue to be completed as per the audit schedule to monitor effectiveness of laundry and cleaning processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>The emergency and disaster manual includes dealing with emergencies and disasters, essential locations, internal emergencies, and external emergencies. Emergencies, first aid and CPR are included in the mandatory in-services programme and the annual training plan includes emergency training. A review of staff files confirmed that staff have completed induction that includes health and safety and emergency preparedness. First aid training for staff is in place with a registered nurse on duty at all times with a current first aid certificate.</p> <p>The service has alternative power systems (gas hobs) in place to be able to cook in the event of a power failure. Emergency lighting can run for at least two hours if not more and a generator is able to provide further support for extended periods. There is a civil defence kit for the whole facility and drinkable water is stored in large holding tanks. The volume of stored water for emergencies meets civil defence guidelines. A civil defence folder includes procedures specific to the facility and organisation.</p> <p>Partial Provisional:</p> <p>The call bell system was sighted in all bedrooms, bathrooms and toilets and communal areas. The call bell system in the new wing is not yet operationalised.</p> <p>The fire evacuation plan has been approved by the fire service for the existing service with a plan in the process of being submitted to Fire Service New Zealand for the new wing. The doors of the building can be locked, and security is relevant to the needs of the residents and staff, with checks by staff prior to dusk.</p> <p>Emergency equipment such as sprinklers, smoke detectors and other have been installed and are operational. For the new wing, this is signed out as part of the CPU (link 1.4.2.1).</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>General living areas and resident rooms are heated and ventilated. There is underfloor heating in the current building including the new wing. There is plenty of natural light in all areas with external sliding doors in bedrooms and communal areas and windows in all rooms able to be opened.</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>CHT Carnarvon has implemented the CHT 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. The programme will be able to accommodate the additional beds. All infections are collected via the VCare reporting system. An experienced registered nurse is the designated infection control coordinator with support from the unit manager and all staff as the quality management committee (infection control team). Minutes are available for staff. Regular six-monthly internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p> <p>The service has processes and procedures implemented to manage the risk posted by Covid 19. All residents are screened using the Covid 19 screen form prior to admission. New residents are isolated for 14 days following admission. Existing residents all have daily temperatures recorded. All visitors complete a health questionnaire and wear masks.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team, bug control and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and</p>	FA	<p>There are CHT infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>

procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred including additional training around PPE and outbreak management. The infection control coordinator has completed infection control training and attends annual, service wide, CHT infection control meetings. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is described in CHTs infection control manual. All possible infections are collected using the VCare incident process. The IC coordinator reviews all infection forms each month. All infections that comply with the surveillance definition of an infection are logged on to the IC log and any infections that do not comply with the standard IC definition remain as an incident.</p> <p>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 have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There was one resident with restraint and three residents with an enabler. Enabler use is voluntary. All necessary documentation has been completed in relation to the restraint. Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP) and enabler usage. 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 meetings. The unit manager (registered nurse) is the designated restraint coordinator.</p> <p>The service has worked hard to minimise use of restraint with the number of residents using restraint having decreased from seven residents using restraint at the last audit and from four residents using enablers at the last audit.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The unit manager is the restraint coordinator. Assessment and approval processes for restraint use included the restraint coordinator, registered nurses, resident, or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service has comprehensive assessment forms for residents who require restraint or enabler interventions. These are well used. Decisions around restraint use are made in partnership with the family/whānau in the file reviewed. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment (completed verbally) and consent process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is put in place only where it is clinically indicated and justified and approval processes. An assessment process is completed for all restraints and enablers. The files reviewed (one for a resident using restraint and one for a resident using an enabler) had a care plan that reflected risks identified with the use of the device and risks for the resident.</p> <p>Monitoring forms that included regular two hourly monitoring (or more frequent) were in the restraint files reviewed. The service has a restraint and enablers register, which is updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every six months as part of the MDT review at which family are present. In the restraint file reviewed, evaluations had been completed by the restraint coordinator six monthly. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Interviews with registered nurses and HCAs demonstrated understanding of the individualised needs of residents. All resident files reviewed included an up-to-date care plan, however not all care plans reviewed included the risks associated with some medications or recognition of side effects. Regular weight monitoring, turning charts and intake and fluid balance charts in use were documented, one resident did not have blood sugar monitoring documented as often as required. Pain monitoring was documented as needed and one resident with oxygen therapy was being monitored as needed.</p>	<p>(i). Four of seven wound care evaluations had not been completed as per the service policies and did not include all aspects of the wound evaluation.</p> <p>(ii). The pressure injuries did not have a formal assessment and wound care plan documented.</p> <p>(iii). Two rest home and one hospital level resident did not have the risks associated with warfarin use in the care</p>	<p>(i). Ensure that all wound care plans are evaluated according to policy.</p> <p>(ii). Ensure that all wounds have a documented assessment and wound care plan.</p> <p>(iii). Ensure that the risks associated</p>

			<p>plan.</p> <p>(iv). One hospital level resident's care plan documented the risk of hypoglycaemia, but not how to recognise the issue.</p> <p>(v). One rest home resident required twice daily blood sugar monitoring; the monitoring was only documented once a day.</p> <p>(vi) There is no evidence in the resident record that cultural needs for Māori, Pacific or Indian residents are identified as part of the assessment process or interventions documented as part of the care planning process.</p>	<p>with warfarin are documented in the care plan.</p> <p>(iv). Ensure that the signs and symptom of known risks such as hypoglycaemia are included in the care plan.</p> <p>(v). Ensure that monitoring is documented as per plan.</p> <p>(vi). Assess cultural needs for each resident and record interventions in the care plan with this reviewed as per schedule</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>A current building warrant of fitness is displayed for the original building and a certificate of public use is in place for stage 2 of the new build. The new wing is in the process of being completed.</p>	<p>Partial provisional: (i) A certificate for public use (CPU) has yet to be issued for stage 3 of the new build.</p> <p>(ii) The new wings are to</p>	<p>(i) Ensure a copy of the code of compliance is completed and provided to the DHB and</p>

			<p>yet to be completed with furnishings, shelving, cabinetry, paint, and floorings which are to be completed and installed as relevant to each space prior to occupancy.</p> <p>(iii) Hot water is not yet in place and therefore monitoring has not commenced.</p> <p>(iv) Locks and identification labels have not yet been installed in communal bathrooms.</p> <p>(v). Ensuite and communal toilet and bathroom facilities are not yet operationalised including disability rails</p>	<p>HealthCERT.</p> <p>(ii) Ensure that furnishings, shelving, paint, floorings, and handrails are installed to meet resident and staff needs.</p> <p>(iii) Ensure hot water checks are completed.</p> <p>(iv) Ensure communal bathrooms are identifiable and privacy is ensured.</p> <p>(v). Ensure that power, lighting, and water supplies are turned on and safety equipment such as disability rails installed</p> <p>Prior to occupancy days</p>
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<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The new building (stage three) is yet to be completed. In communal areas there is, painting and floor covering completed, wiring to be finished and equipment and furnishings including chattels completed. Equipment is yet to be installed.</p>	<p>Partial provisional: The building is not yet ready for occupancy. Equipment is yet to be installed.</p>	<p>Ensure that the building is ready for occupancy.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	<p>PA Low</p>	<p>A fire evacuation plan approved by Fire Service New Zealand is in place for the facility. A plan is in the process of being submitted to Fire Service New Zealand that is updated to include the new wing.</p>	<p>Partial Provisional: The fire evacuation plan Fire Service New Zealand for the new wing is not yet approved.</p>	<p>Ensure that the fire evacuation plan includes the new wing and this is approved by the Fire Service.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Low</p>	<p>The call bell system is in place in the new wing and ready to be operationalised. This will link to the existing call bell system already installed in the current building.</p>	<p>Partial Provisional: The call bell system is in place in the new wing but not yet operationalised.</p>	<p>Operationalise the call bell system in the new wing.</p> <p>Prior to occupancy days</p>

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

No data to display

End of the report.