

CHT Healthcare Trust - CHT Bernadette

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: 19 November 2020	End date: 20 November 2020	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit: 79			

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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. The service cares for up to 85 residents requiring hospital and rest home level care. There are seven beds temporarily closed due to refurbishment. On the day of the audit, there were 79 residents. The unit manager oversees the service with the support of the area manager and clinical coordinator. Residents, relatives and the GP interviewed spoke positively about the care and services provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner

This audit did not identify any areas for improvement.

The previous shortfall from the certification audit around resident surveys has been addressed.

The shortfalls from the partial provisional audit relating to the new building including: a certificate of public use; a fire evacuation scheme; call bell system; transfer of the kitchen and laundry to the new building; completion of the walkways between the new and existing buildings; and transfer of equipment and furniture from the old to new building were all addressed prior to occupancy.

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.

Information about the Code of Rights and complaints process is available to residents and families. An information booklet provides information for family, friends and visitors to the facility. There are regular resident and family meetings. Family are involved in the resident care plans and evaluations. Complaints processes are implemented, and complaints and concerns are actively managed and well documented. Management operate an open-door policy.

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.

The quality and risk management programme includes service philosophy, goals and a quality planner. The CHT management team at head office and the area manager provide support and direction to the unit manager. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk, health and safety and infection control management processes. Residents/family meetings are held. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with on-line and on-site training plan. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

Standards applicable to this service fully attained.

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 input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent health care assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements 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.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Residents commented positively on the meals.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building holds a current warrant of fitness. There is a preventative and reactive maintenance programme. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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CHT Bernadette has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service uses restraint as a last resort. On the day of audit, there was one resident with an enabler and two residents with restraints.

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 coordinator is responsible for the collation of infections and reporting results of surveillance to the quality, health and safety, infection control meeting. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. Communication, screening, education and resources were well managed during the Covid-19 lockdown period. Precautions and screening continue.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	46	0	0	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. The unit manager receives any complaints, and these are investigated in consultation with the clinical coordinator.</p> <p>Verbal, written and email complaints are documented, acknowledged and investigated within Health and Disability Commissioner (HDC) timeframes. There was evidence of written responses, corrective actions and meetings including follow-up meetings and phone calls to ensure the complainant was satisfied with the outcome. An electronic complaints' register is maintained.</p> <p>There had been one HDC complaint in October 2019 which had been investigated, corrective actions completed and closed out in July 2020. The service has implemented closer GP monitoring of warfarin results and timely specimens to the laboratory with the clinical coordinator completing a phlebotomy competency.</p> <p>There have been seven internal complaints between February 2020 and September 2020 which have been resolved. There was one HDC complaint in April 2020 which was investigated and withdrawn with no further action required.</p> <p>Complaints received and corrective actions are discussed in the quarterly quality meetings. Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the RNs and management team.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Ten residents interviewed (five rest home and five hospital) and family member stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents reviewed identified the relative had been notified. This was confirmed on interview with a hospital family member. Resident and family meetings have recommenced post Covid-19 lockdown. Minutes signed evidenced discussion around all services including the building progress and facility upgrades. Residents interviewed stated the staff and management are very approachable.</p> <p>There is access to interpreters as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>CHT Bernadette is owned and operated by the CHT Healthcare Trust. The service currently provides rest home and hospital level of care for up to 85 residents. On the day of the audit, there were 79 residents in total. All beds are dual purpose and there are two double rooms. There were 43 hospital level residents including one resident under a palliative care contract (PCC), one resident under ACC funding and three younger persons (with physical disabilities). There were 36 rest home level residents including one younger person. There were no residents under respite care on the day of audit.</p> <p>Stage 1 new build of a 19-bed dual purpose unit (includes two double rooms) has been completed. Stage 2 which is the refurbishment of the final existing dual-purpose wing is almost completed. Six resident rooms (in Bayfair wing) remain closed until the contractor's complete refurbishment. There is one other resident room closed for remedial work. When stage 2 is completed there will be 92 beds available.</p> <p>CHT has an overall business/strategic plan that includes the values and vision of the organisation: compassion, companionship, care, comfort and connected. There are area managers that report to the CEO at head office. CHT Bernadette has a unit specific performance plan that identifies annual goals and key performance indicators (KPI) such as reduction of falls, health and safety and increasing resident satisfaction in services. A focus group has been set up to develop quality improvements around care, activities and food satisfaction. The unit managers review KPIs and progress towards meeting goals at the monthly meeting with the area manager and CEO.</p> <p>The unit manager/registered nurse has been in the role at Bernadette for two years and has previous experience in aged care. She completed a post graduate paper in health and leadership management in 2018. Education is held at the monthly manager meetings at head office and has included complaints management and quality management systems. The unit manager has recently attended the aged care conference. She is supported by an area manager/RN (present during the audit) and an experienced clinical coordinator. The clinical coordinator has been in the role 21 months and transferred from another CHT site where she was the clinical coordinator since 2015. She attends the monthly unit manager meetings and is a careerforce assessor.</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 a unit business/strategic plan that includes quality goals and risk management plans. The unit manager provides oversight of the quality programme and provides monthly reports to the area manager and head office. The quality and risk management programme is designed to monitor contractual and standards compliance.</p> <p>A document control system is in place with all quality documents reviewed by areas managers. New policies or changes to policy are sent to the unit and communicated to staff via meetings and their individual emails. Staff have access to the electronic “file vision” documents including policies and procedures.</p> <p>Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints and internal audit outcomes. Organisational benchmarking occurs and quality improvements developed where results are less than expected. Staff interviewed confirmed they are kept informed on quality data, trends and correctives actions at the quarterly combined quality/health and safety meetings, general facility meetings and RN meetings. Copies of minutes are posted in the staff room.</p> <p>The area manager completes six-monthly internal audits against core standards, restraint and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off by the unit manager when completed.</p> <p>Annual resident/relative surveys have been completed for 2019 and 2020. The results have been collated at head office and feedback to the service. A corrective action plan for 2019 and 2020 were sighted for areas requiring improvement. The quality improvements are linked to the unit quality plan and monitored for progress against identified goals. There was an area identified for improvement around meals and an action plan developed and implemented. Interviews with 10 residents and one relative stated they were satisfied with the meals and were offered alternative foods for dislikes/allergies. The previous finding around corrective action plans for areas of improvement has been addressed.</p> <p>The service has a health and safety programme in place. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is included in the quarterly combined quality/health and safety/infection control meetings. The health and safety representative/RN (interviewed) has completed health and safety training in September 2020. The health and safety representative confirmed staff were observant and promptly reported any hazards, unsafe situations and faulty equipment. There is a current hazard register in place. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling (taken by the physiotherapist). There have been contractors on site since January 2020 (except during lockdown) and the health and safety representative stated the staff had been kept informed on building progress and potential hazards. There were regular meetings with the contractors. On the day of audit, the main entrance and one corridor was safely cordoned off while the last six rooms were being refurbished. There was a temporary main entrance and a contractor’s hazard board in place.</p>
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<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>Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. Ten resident related incident reports for October were reviewed. Paper-based incident forms are completed, reviewed by the RN and corrective/preventative actions monitored by the clinical coordinator. The clinical coordinator enters incident data into the electronic system which collates events. Monthly reports are analysed for trends, corrective actions and discussed at the quality/health and safety/infection control meeting and other facility meetings. All events have a checklist completed which includes notification of the relatives. Neurological observations were commenced for unwitnessed falls where the resident could not state if they hit their head or if there was a potential head injury. Documentation including care plan interventions for falls prevention were fully documented.</p> <p>There is an accidents and incidents reporting policy. There is a discussion of incidents/accidents at quality/health and safety, clinical meetings and handovers, including actions to minimise recurrence. Staff interviewed confirms incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been six Section 31 notifications since the previous audit including two unstageable pressure injuries (June 2020 and September 2020), three police notifications (two missing persons and one missing medication) and one property incident. Three outbreaks were notified to the DHB in a timely manner (link 3.5).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	FA	<p>There are human resources policies to support recruitment practices including relevant checks to validate the individual's qualifications, experience and veracity. Five staff files reviewed (one clinical coordinator, one RN's, two three healthcare assistants and one activity coordinator) contained all relevant employment documentation and job descriptions. Current practising certificates were sighted for the RN's, and allied health professionals. All staff sign a code of conduct, code of confidentiality and information technology policy. Performance appraisals were up to date.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>The service uses the Altura on-line training. The Altura education planner covers the compulsory education</p>

practice and meet the requirements of legislation.		<p>requirements. There are additional on-site clinical in services held by external trainers/speakers such as hospice, chemical provider, physiotherapist and the PHO (primary health organisation) residential aged care nurse specialist.</p> <p>The RNs have an opportunity to attend DHB education days as offered. Nine of the twelve RN's have completed interRAI training.</p> <p>The clinical coordinator is a career force assessor and is currently supporting six HCAs through their career force papers. The HCAs interviewed feel well supported to attend education opportunities.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>CHT organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The unit manager and clinical coordinator work full time Monday to Friday and share the on call 24/7. There is a casual pool of staff whose hours were increased to assist during the COVID-19 lockdown. The service use a preferred Bureau for RN cover as needed.</p> <p>Interviews with residents and relative indicated there are generally sufficient staff to meet resident needs. The registered nurse on each shift is aware that staff working short shifts can be extended to meet increased resident needs. The unit manager is developing a roster in preparation for the opening of the six beds after refurbishment has finished.</p> <p>The facility is divided into four wings: (i) Mauao, (ii) Pilot Bay, (iii) Bayfair and Welcome Bay and (iv) Omanu and Papamoa. There are three RNs on morning duty, two RNs on the afternoon and one RN on night shift to cover all areas.</p> <p>Mauao (25 beds) has 24 residents (14 hospital and 10 rest home). On morning shift there are two HCAs on the full shift 7am-3pm and one HCA on the short shift 7am-12 noon and on afternoons two HCAs on the full shift 2pm-11pm.</p> <p>Pilot Bay (25 beds with one bed temporarily closed) has 22 residents (11 hospital and 11 rest home). On morning shift there are two HCAs on the full shift 7am-3pm and one HCA on the short shift 7am-12 noon and on afternoons two HCAs on the full shift 3pm to 11pm.</p> <p>Bayfair and Welcome Bay (26 beds with six beds currently closed for refurbishment) has 17 residents (nine hospital and 8 rest home). On morning shift there is one HCA on the full shift 7am-3pm and one HCA on the short shift 7am-12.</p> <p>Omanu and Papamoa (19 beds including two double rooms) has 16 residents (nine hospital and eight rest home). On morning shift there is one HCA on the full shift 7am-3pm and one HCA on the short shift 7am-12.</p> <p>There are two HCAs on the afternoon shift 3-11pm and one on the short shift 4pm-9pm who work between the Bayfair and Welcome Bay and Omanu and Papamoa wings.</p> <p>On night shift there are four HCAs, one in each wing who work as a team to meet the needs of residents who</p>

		require two person cares.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three resident self-administering on the day of audit. Consent forms had been signed and the residents deemed competent to self-administer. The medications were kept in a locked drawer. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RN's and medication competent HCA's administer all medications. Staff attend annual education and have an annual medication competency completed. All RN's are syringe driver trained by the hospice. The medication fridge temperature is checked weekly and the medication air temperature is checked daily. One of the medication rooms recorded high temperatures. This has been addressed by the service. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Twelve medication charts were reviewed (eight hospital and four rest home). Medications are reviewed at least three-monthly by the G.P. There was photo identification and allergy status recorded. As required medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The contracted kitchen service has a site manager who is a chef. He covers Monday to Friday and there is a weekend cook. There are three kitchen hands who cover morning and evening shifts. All kitchen staff have food safety and hand hygiene training. The site manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked onsite. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by the head office dietitian. Alternative options such as a salad or sandwiches are offered for residents with dislikes. If a resident has unintentional weight loss, they are commenced on the REAP (replenish and energy protein) programme. All resident/family interviewed were satisfied with the meals. The food control plan was last verified on 27 March 2020.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when a resident knocks their head or for an unwitnessed fall.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. A wound care nurse specialist has been consulted when appropriate. Photos are taken to record the wound's progress. There are currently two pressure injuries. Both are facility acquired. One is stage two and the other is unstageable but improving. A section 31 was completed. The wound care nurse specialist has seen both pressure injuries and given advice on dressing products.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, pain, food and fluid and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</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>There is one diversional therapist who works 20 hours one week and 16 hours the next week. There is one activities coordinator who works 20 hours a week. Both work across all areas. On the day of audit residents were observed participating in an exercise class, playing bingo, listening to a visiting lady's choir and enjoying Happy Hour.</p> <p>There is a weekly programme in large print on noticeboards in all areas and every resident receives a copy for their room. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>There is an interdenominational church service every Monday. A priest will come in to give Roman Catholics communion.</p> <p>There are van outings twice weekly. Both activities staff have completed first aid certificates. Special events like birthdays, Easter, Diwali, Anzac Day and the Melbourne Cup are celebrated. There is entertainment every week at Happy Hour. The library bus visits the facility. The facility has a cat and there is pet therapy twice weekly.</p> <p>There is community input from the local preschools and volunteers come in to assist with bingo and to chat with residents.</p>

		<p>Those residents who are able go out shopping and for coffee. They also go on picnics.</p> <p>Three of the YPD residents enjoy the activities in the facility but are not well enough to go out. The other YPD resident loves to go out walking and to shops and cafes. The activities staff ensure that YPD residents have access to up to date DVD's.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held three-monthly. Residents interviewed confirmed there were plenty of activities to be involved in if they wished.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All long-term care plans for residents who had been at the service six-months or longer had been evaluated. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The short-term care plan for the resident under PCC is reviewed and updated as changes occur. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family member interviewed confirmed that they are informed of any changes to the care plan.</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>	FA	<p>The building now holds a current warrant of fitness which expires 22 April 2021. Previously the facility had a certificate for public use.</p> <p>There is a preventative and reactive maintenance programme. Hot water temperatures are monitored.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p> <p>Residents can now move freely and safely between new and existing buildings via safe and accessible walkways. Electricity, plumbing and utilities meet the needs of residents. Interior painting and flooring have been completed. The kitchen and sluice room are now fully operational. Pathways driveways and outdoor areas have now been completed. All previous findings from the partial provisional audit were addressed prior to occupancy.</p>
<p>Standard 1.4.7: Essential,</p>	FA	<p>The fire evacuation plan for the new building reconfiguration was approved by the fire service 29 November 2019. Forty staff attended an orientation including fire safety and security training for the new wing on 10 December 2019.</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>This was taken by fire security services and the CHT property manager. A fire drill was held following occupancy of the new wing and six monthly thereafter. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are adequate supplies in the event of a civil defence emergency. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are calls bells installed throughout the facility including the new build, in all resident rooms and communal areas. Sensor mats sound as a separate alert in the call bell system and shows u as a “bed exit” on the corridor display units. Monthly call bell audits are completed, and the call bell supplier is readily available.</p> <p>The building is secure after hours with all external fire doors meet fire regulation and able to be opened in an emergency. The previous findings from the partial provisional audit around fire evacuation, call bells and external doors were addressed prior to occupancy.</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>The infection control coordinator/RN (appointed May 2020) and clinical coordinator oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is entered into the electronic system, collated, monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are documented on the monthly summary which is countersigned by the GP. Results of surveillance is discussed at the combined quality/health and safety and infection control meetings. Meeting minutes, data and graphs are made available to staff.</p> <p>There have been two gastroenteritis outbreaks since the last audit (February and December 2019) and one influenza outbreak in July 2019. Email notifications and correspondence made to Public Health for the outbreaks were sighted.</p> <p>There was additional infection control training during Covid-19 focusing on hand hygiene and personal protective clothing with practical demonstrations and videos for staff. There were “everyday” meetings and staff and residents interviewed stated they were kept informed and updated daily. Admissions during the lockdown period were screened and isolated for two weeks. There are plenty of infection control and prevention resources available and hand sanitizers throughout the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There was one hospital resident with a bedrail enabler and the file reviewed included voluntary consent. There were two hospital residents with bedrail restraints. All necessary documentation has been completed in the one restraint file</p>

that the use of restraint is actively minimised.		<p>reviewed.</p> <p>Staff receive training/education on restraint/enablers and restraint is discussed as part of the quality and clinical staff meetings. A registered nurse is the designated restraint coordinator. supported by the clinical coordinator. Six monthly restraint audits are completed.</p>
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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.

No data to display

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.