

CHT Healthcare Trust - CHT Te Awamutu Home & Hospital

Introduction

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

The audit has been conducted by 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 Te Awamutu Home & Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care	
Dates of audit:	Start date: 19 January 2021	End date: 20 January 2021
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	59	

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 Te Awamutu is owned and operated by the CHT Healthcare Trust. The service currently provides care for up to 60 residents requiring hospital (geriatric and medical), dementia, and rest home level care. On the day of the audit, there were 59 residents.

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, staff, management, and general practitioner.

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

This audit has identified one area requiring improvement around monitoring of fridge temperatures.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff at CHT Te Awamutu strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication, and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme includes service philosophy, goals, and a quality planner. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents'/family meetings have been 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 a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner, nurse practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

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

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

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.
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Safety datasheets and product sheets are available. The building holds a current warrant of fitness. All internal and external areas are safe and well maintained. A reactive and preventative maintenance programme is in place. The rest home and hospital rooms each have an ensuite, the dementia unit has ensuite toilets and communal showers. Fixtures, fittings, and flooring are appropriate. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. All resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. Residents' rooms, communal bathrooms and living areas all have call bells.

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 Te Awamutu has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. Restraint and enablers were not in use on the days of audit. Restraint management processes are adhered to.

Infection prevention and control

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

Standards applicable to this service fully attained.

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 (a registered nurse) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided by CHT head office. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	44	0	1	0	0	0
Criteria	0	92	0	1	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 Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with 15 staff (eight healthcare assistants, one registered nurse (RN), two activities coordinators, one cook, one maintenance staff, cook, one clinical coordinator), one unit manager and one area manager confirmed their familiarity with the Code.</p> <p>Visual observations during the audit and the review of eight resident records and other documentation indicated that staff are respectful of residents and incorporate the principals of the Code into their practice. The service provides information on the Code to families and residents on admission.</p> <p>Interviews with nine residents ((three rest home, five hospital and one at rest home level of care- post-acute convalescent care) and five families (two hospital and three dementia unit) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. There is a culture in the service that was observed during the audit that is about choice and involving the resident in giving consent to activities of daily living. Staff interviewed demonstrated an understanding of informed consent processes.</p> <p>Residents and relatives confirmed that they discuss the principles of consent with relatives and residents on</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>entry to the service with consent for service and confidentiality of information documented on admission. All resident files reviewed included signed consent forms completed on the day of admission.</p> <p>All residents have the choice to make an advanced directive if they are deemed competent by the general practitioner or nurse practitioner. In records reviewed, all competent residents have a documented advanced directive. The resident signs these if competent. The general practitioner or nurse practitioner has made a decision for some residents as not for resuscitation, with this noted as being a clinical medical decision.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>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 and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents have open access to visitors of their choice. There is a visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Access to community support/interest groups is facilitated for residents as appropriate with some residents observed to interact in the community on the day of audit.</p> <p>The activities staff are available to take residents on community visits and staff are available to take people to appointments if family are not able to provide transport.</p> <p>Residents interviewed, confirmed they can have access to visitors of their choice at any time and are supported to access services within the community. There were a large number of family visiting on days of the audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process.</p> <p>All staff interviewed were able to describe the process around reporting complaints. There is a complaints' register. There were seven complaints made in 2020. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to raise any concerns.</p>

		There have been no complaints from external providers since the last audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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 enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act 2020 and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage to maintain privacy and respect of personal property. All residents interviewed stated their needs were met. A policy describes spiritual care. Church services are held at least weekly. All residents interviewed indicated that residents' spiritual needs are being met when required with some stating that they were supported to attend services of their choice in the community.</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 interviewed confirmed that they were encouraged to be as independent as possible.</p> <p>There are quiet, low stimulus areas that provide privacy for residents in the dementia unit and opportunities during the day for residents in the dementia unit to interact with others in the service with appropriate supervision.</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</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no Māori residents on the day of audit. Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process. Staff have received training on the Treaty of Waitangi. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. There are also staff who can speak te reo Māori. Kaumatua from Tainui can provide advice and support when required.</p>

individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Family members (including those on behalf of residents in the dementia unit) interviewed, confirmed that values and beliefs are respected by staff. Information gathered during assessment including residents' cultural beliefs and values, are used to develop a care plan. Staff receive training on cultural awareness. Staff speak a range of languages including Afrikaans and Indian dialects.</p> <p>Staff in the dementia unit described paying particular attention to knowing the culture, values and beliefs of each resident and emphasising this in daily care.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The registered nurses supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them.</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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include the requirement to attend orientation and ongoing in-service training.</p> <p>The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. The unit manager is responsible for coordinating the internal audit programme. An electronic system is used to extract data from the electronic resident management system and analyse incidents, infections, falls, unintended weight loss, pressure injuries, skin tears and complaints. This extract is used to assist in implementing strategies to reduce further events. Evidence-based practice is evident, promoting and encouraging good practice. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and</p>

		<p>support provided.</p> <p>Staff stated that both the general practitioner and nurse practitioner who visit the service provide them with information and support whenever required. A review of resident files confirmed that staff contact specialists and the general practitioner and/or nurse practitioner when required. The general practitioner interviewed stated that the service provided a high quality of care.</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>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy around open disclosure alerts staff to their responsibility to notify family/next of kin of any accidents/incidents that occur. Sixteen incidents/accidents forms were reviewed for October to December 2020. The forms included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p> <p>While some meetings have not been held in 2020 as a result of the need for isolation during the Covid-19 pandemic as per the governments directive, there has been clear communication from head office through the unit and area manager. This has resulted in staff continuing to provide appropriate care to residents during the pandemic. Residents and family stated that the service had provided good information during Covid lockdown periods and they were kept informed at all times of expectations and the progress of their family member.</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 Te Awamutu is owned and operated by the CHT Healthcare Trust. The service provides rest home, dementia, and hospital level care for up to 60 residents. On the day of the audit, there were 59 residents in total: 10 rest home level with one resident using respite level care in the rest home; 30 hospital level in the 40 dual purpose bed unit; and 19 residents in the 20-bed dementia unit (made up of two 10-bed units). All residents are contracted under the Aged Residential Related Care contract with one identified as being under Transition to Home PACC (post-acute convalescent care-) – Rest Home. There are no residents under 65 years.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. They have extensive experience in respiratory nursing and in aged care for five years and has been in the role for 18 months. The clinical coordinator graduated in June 2020 and has been in the position since October 2020 following the resignation of the previous clinical coordinator. The unit manager reports to the area manager weekly on a variety of operational issues. Both the unit and area managers provide support for the clinical coordinator.</p> <p>CHT has an overall business/strategic plan and CHT Te Awamutu has a facility quality and risk management programme in place for the current year. The business/strategic plan and quality and risk management programme for 2020 has been reviewed. The organisation has a philosophy of care, which includes a mission</p>

		<p>statement.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Generally, in CHT, the clinical coordinator would be placed in charge with the area manager providing support. If this occurred (noting that the unit manager has no planned leave), then the area manager would provide support for the clinical coordinator, with support from the registered nurses and care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans. Interviews with staff confirmed that quality data is discussed at the quarterly quality and health and safety meetings which have been held in March, July, September, and November 2020. There were staff meetings held monthly however these have been replaced with cluster meetings to which all staff are invited. 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 reviewed at national level, with input from facility staff every two years. There are also local unit review meetings with the chief executive officer, area manager, unit manager and clinical coordinator attending. These have been held in March, June, and monthly thereafter to December 2020. Registered nurse meetings are also held monthly noting that there were a reduced number of meetings during lockdown level four period, of Covid-19 pandemic. New/updated/reviewed policies are sent from head office. Staff have access to manuals. Resident/relative meetings are held twice a year (March and November 2020). Head office sent emails and letters to residents and family during the lockdown periods of the Covid-19 pandemic. Restraint and enabler use is reported within the clinical and staff meetings.</p> <p>Data is collected in relation to a variety of quality activities and a comprehensive internal audit has been implemented. The Qlik Sense 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. Qlik 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</p>

		<p>satisfied with care provided. Documentation confirmed that corrective action plans are developed when issues are raised and there is evidence of resolution of issues completed in a timely manner.</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 quality/health and safety meetings. These are also discussed at the registered nurse and staff meetings.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> <p>Residents/relatives' satisfaction survey for 2020 shows a 70% to 80% satisfaction year to date. The previous data at the same time in the previous year documented a similar response.</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 monthly clinical and staff meetings including actions to minimise recurrence. Sixteen resident incident forms sampled demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There was appropriate notification made around the change in unit manager, clinical coordinator appointment, a gastric outbreak in October 2017 and two for pressure injuries – one unstageable pressure injury and one stage four.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical coordinator, two registered nurses, one activities coordinator and three healthcare assistants) and there is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2020 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Four of the eight registered nurses have completed interRAI training with the clinical coordinator currently enrolled in the</p>

		<p>programme.</p> <p>There are nine healthcare assistants who work in the dementia unit with seven having completed dementia unit standards as required in the contract. There is one casual staff who relieves in the unit who has not completed dementia training, however they always works with a senior HCA (who has completed the unit standards).</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>Policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN on site at any time. Activities are provided seven days a week. Staff working on the days of the audit were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>There is an RN for each shift, seven days a week, plus an additional RN from midday to 8 pm.</p> <p>Healthcare assistants are staffed according to units as follows.</p> <p>There are four wings; Koru one has seven hospital and three rest home residents, Koru two has eight hospital and two rest home resident, Mana three has six hospital and four rest home residents and Mana four has eight hospital and two rest home residents including the respite resident. Each wing has the same staffing of; AM one long and one short shift, PM one long and one short shift. There are two healthcare assistants over the four wings at night.</p> <p>Dementia (two wings; 19 residents); the clinical coordinator assists in the AM and undertakes the medication rounds. For the AM and PM shifts, there is one long-shift and one short-shift HCA on each with a registered nurse rostered from 12 pm to 8.30 pm seven days a week. On night shift there is one HCA with the dementia unit with both units operating as one overnight.</p> <p>A review of rosters evidenced that unplanned leave is covered.</p> <p>Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the management team who respond quickly to afterhours calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable,</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant</p>

accurately recorded, current, confidential, and accessible when required.		healthcare assistant or registered nurse.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The eight admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Specific information about the dementia unit is provided to families. Family members reported that the unit manager or unit coordinator are available to answer any questions regarding the admission process.</p> <p>The respite resident's service use is monitored by the DHB.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. One file reviewed was of a resident who had been transferred to hospital acutely post-fall. All appropriate documentation and communication had been completed. Transfer to the hospital and back to the facility post-discharge, is documented in progress notes.</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</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. 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. RNs and senior medication competent HCAs administer medications. Staff have up-to-date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperature are checked daily. Eye drops are dated once opened.</p>

guidelines.		Staff sign for the administration of medications electronically. Sixteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
<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>	PA Low	<p>Food and laundry services are outsourced to a contractor – 'Compass'. The kitchen unit manager oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised and a current approved food control plan was in evidence. The kitchen had the audit to review this on day one of this certification audit. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be 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 at all meals and within safe limits, however four of four food fridges in resident areas were outside of the accepted temperature range with no corrective actions documented.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is written and approved by an external dietitian.</p> <p>All resident/families interviewed are happy with the meals. Additional snacks are available at all times in the dementia unit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4:	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed

<p>Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>for all long-term residents' files reviewed. Initial interRAI assessments and reviews were evident in printed format in all resident files. Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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 will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The nurse practitioner and GP interviewed were complimentary of the service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included two chronic wounds, four skin tears, a stage one sacral pressure injury (facility acquired) and one resident with four DHB-acquired pressure injuries (two stage one, one stage four and one unstageable). The stage four and unstageable had section 31s submitted, appropriate wound care plans and specialist input.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, and wounds. All monitoring requirements including neurological observations had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery</p>	<p>FA</p>	<p>There are three activity coordinators covering seven days per week who plan and lead all activities. The activities programme is overseen and signed off by a diversional therapist employed by CHT at another facility. The dementia unit has a dedicated activity programme which is facilitated by the activity coordinator and healthcare assistants. The dementia unit residents can also join in the hospital and rest home activities.</p>

<p>plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Residents in the dementia unit have detailed 24-hour care plans and 24-hour activity plans that are personalised to the individual. On the days of audit residents were observed participating in activities.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, nerf gun hunts and bingo.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are weekly outings, and the service utilises a wheelchair accessible taxi and volunteer community transport as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as choirs and children's groups.</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. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The eight resident care plans reviewed (apart from the short-term respite) had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</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,</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The unit coordinator interviewed, gave examples of where a resident's condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the unit coordinator and registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>

or provided to meet consumer choice/needs.		
<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 policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</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 holds a building warrant of fitness which expires May 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, courtyards and gardens are well maintained. All courtyards have attractive features and are easily accessible to residents. The dementia unit garden is securely fenced. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal</p>	FA	<p>Most of the rest home and hospital rooms each have an ensuite, the dementia unit has ensuite toilets and communal showers. All rooms have hand basins. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant.</p> <p>Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<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	All resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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	There are large and small communal areas. Activities occur in all areas on a rotating basis, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	All laundry is outsourced. There are two separate rooms – a 'dirty' room for linen/clothing awaiting collection and a 'clean' room for deliveries. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches,

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>radio, and batteries), emergency power and barbeque. The facility keeps 50 litres of emergency water per resident on site in three external water tanks. A generator is readily available on standby through a local company, the facility having a generator access port situated on an external wall. The area manager interviewed on day of audit advised of facility plans to purchase their own generator in the near future.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. There is security lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed, stated that this is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<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>The infection control coordinator (ICC) is an RN. Responsibility for infection control is described in the job description. The ICC oversees infection control for the facility, reviews incidents on VCare and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by CHT.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There has been one outbreak in the previous year which was appropriately managed.</p>
<p>Standard 3.2: Implementing the infection control</p>	FA	<p>The ICC role was being overseen by the unit manager on the day of audit and has attended online CHT training in infection control. There is access to infection control expertise within the DHB, CHT, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics. The ICC also liaises and meets regularly</p>

<p>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>		<p>with the infection control committee. Overall effectiveness of the programme is monitored by CHT head office and subject to a monthly review meeting with the area manager.</p> <p>A COVID strategy and pandemic plan was available to staff on site with education and associated resources relating to hand hygiene, PPE and donning/doffing procedures.</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 procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a CHT infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The ICC is responsible for coordinating education and ensuring staff complete the online training available on the Altura online education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection</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>		<p>control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Meeting minutes are available to staff. Results from laboratory tests are available monthly. There has been one outbreak in 2020 which was appropriately managed.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Restraint and enablers were not in use on the days of audit. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff training/education on restraint/enablers has been provided in 2020. Restraint is discussed as part of staff meetings. A registered nurse is the designated restraint coordinator.</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 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	Food temperatures are checked at all meals and within safe limits, however four of four food fridges in resident areas were outside of the accepted temperature range with no corrective actions documented.	Four of four fridges in resident lounge/dining areas showed temperatures above that accepted in policy.	<p>Ensure fridge temperatures are within the range stated by policy.</p> <p>90 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.