

# CHT Healthcare Trust - Waiuku Hospital and Rest Home

---

## 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:

<b>Legal entity:</b>	CHT Healthcare Trust
<b>Premises audited:</b>	Waiuku Hospital and Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 22 July 2021    End date: 23 July 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	58

# 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

Waiuku is part of the CHT group of facilities. The facility is purpose-built providing two levels of care (hospital – geriatric/medical and rest home for up to 60 residents. On the day of audit there were 58 residents. The residents and relatives spoke positively about the care provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

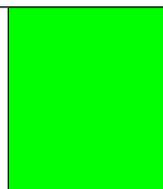
There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the quality and risk management programme. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

There were no areas for improvement identified at this audit.

## 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.

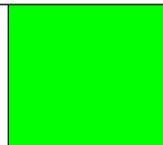


Standards applicable to this service fully attained.

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as: privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family state they are kept well informed on their relative's health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

## 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.



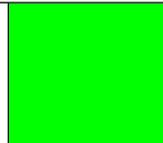
Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. CHT Waiuku has a fully implemented, robust quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has a training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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.

The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital and dementia care residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet prescribing requirements and had been reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being provided 24 hours per day.

## 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 has a current building warrant of fitness certificate, and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. A staff member trained in CPR and first aid is on duty at all times.

## 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.
---	--	--

There are policies and procedures on safe restraint use and enablers. A registered nurse is the restraint coordinator. On the day of the audit, there were two residents with restraints in use (lap belts) and one resident using bed rails as an enabler. Staff receive training around restraint and challenging behaviours.

## 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 prevention and control programme include policies, standards and procedures to guide staff. 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 (RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking with other CHT facilities. There has been one outbreak since the last audit which was appropriately managed.

## 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)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	0	101	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	There are policies and procedures in place around resident rights. Four residents (two rest home and two hospital level of care including one resident on an ACC contract), and five relatives (five hospital level) interviewed, confirmed that information has been provided around the code of rights. Residents state that their rights are respected when receiving services and care. Discussion with seven health care assistants (HCAs), four registered nurses (RN), two activities coordinators, a chef, maintenance staff and one cleaner identified that they are aware of The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) and could describe the key principles of resident's rights when delivering care.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in eight resident files (four hospital and four rest home) were signed by the resident or their enduring power of attorney (EPOA). Written consents were sighted for specific procedures.  Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the resident's file where required. Staff interviewed, confirmed verbal consent is obtained when delivering care.  Resident files of long-term residents have signed admission agreements, and the interim funding care

informed consent.		resident has a signed short-term agreement.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. A representative from advocacy services visits six monthly and attends resident and staff meetings. Pamphlets on advocacy services are available at the entrance.</p> <p>Interviews with the residents and relatives confirms their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.</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>	FA	<p>The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirm that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has actively promoted community involvement including placement of college students for community service, facilitating practical experience for college HCA students, visits from the local college choir, brownies, cubs and scouts and cultural groups. Several local groups and various individuals volunteer at CHT Waiuku.</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>	FA	<p>There is a complaints policy/procedure in place and the complaints process is provided to residents and relatives on entry to the service, complaints forms are available to residents and relatives. A record of all complaints is maintained on the on-line complaint register. The facility manager manages complaints.</p> <p>Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints and discussion around concerns, complaints and compliments are evident in facility meeting minutes. Discussion around concerns, complaints and compliments are evident in facility meeting minutes</p> <p>Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in manager and staff meetings. There were nine complaints received in 2020 and one complaint in 2021 year to date. Complaints reviewed have been documented as resolved with appropriate corrective actions implemented.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service has information available on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The Code (English and Māori) is also displayed in the resident areas. There is a welcome information folder that includes information about the Code. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission with either the unit manager or the clinical manager. Residents and relatives state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</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>	<p>FA</p>	<p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff are able to describe how they maintain resident privacy, including knocking on the resident's doors before entering as observed on the day of audit. Education around privacy and dignity, prevention of abuse and neglect in-service is provided as part of the education plan. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are cultural awareness policies and a Māori health plan to guide staff in the delivery of culturally safe care. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with Tainui-Ngai Te Atu and the kapa haka group. Other community representative groups can be accessed as requested. Family/whānau involvement is recognised and acknowledged by staff. There were no residents who identified with Māori culture.</p>
<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</p>	<p>FA</p>	<p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six- monthly to ensure the resident's individual culture, values and beliefs are being met. Care plans reviewed include specific interventions related to individual residents cultural and spiritual needs. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with weekly church services and visiting clergy who provide pastoral care.</p>

beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process meets best practice with regard to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Caregivers interviewed were able to describe how they recognise and report any suspected abuse and the service's zero tolerance policy. Residents interviewed stated that they are treated fairly and with respect.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals at an organisation level. Health care assistants and registered nurses (RNs) have access to internal and external education opportunities. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by clinical staff. The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery. The service employs a physiotherapist for eight hours per week over two dedicated days, who assesses all new residents and completes resident mobility assessments and fall reviews. Residents and families speak positively about the care provided.  The chief executive officer and area manager run staff focus groups twice a year which expand on customer satisfaction surveys and matters of current interest.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Management promote an open-door policy. Relatives/residents are aware of the open-door policy and confirm on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings and annual surveys. The resident meetings are bi-monthly and are attended by the kitchen manager and external speakers such as a health and disability advocate. Residents and relatives receive seasonal newsletters four times a year.  Accident/incident forms reviewed document that relatives have been notified of the incident. Relatives interviewed state they are notified promptly of any changes to resident's health status.  Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.
Standard 1.2.1: Governance	FA	Waiuku is part of the CHT group of facilities. The building is a purpose-built single level facility providing

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>hospital – geriatric/medical and rest home, for up to 60 residents. On the day of audit there were 58 residents cared for in five dual purpose wings. There were 13 rest home level residents and 45 hospital residents including one on an ACC contract and one resident on a primary options acute care contract. All other residents were under the age-related residential care services agreement. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager is a registered nurse who maintains an annual practising certificate and has been in the role for four years. The clinical coordinator is a registered nurse who commenced in her role the week of audit. She trained as an RN in India and immigrated to New Zealand as an RN in February 2014. The clinical coordinator has worked in various roles in aged care and in the DHB since arrival and has previously worked as an acting clinical coordinator in another CHT facility. She is trained in interRAI and has a current first aid certificate. Her medication competencies (including syringe driver) were up to date.</p> <p>The unit manager reports to the area manager weekly on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p> <p>CHT has an overall business/strategic plan and CHT Waiuku has a facility quality and risk management programme in place for the current year. Waiuku has set a number of quality goals, and these also link to the organisation's strategic goals. The unit managers performance plan was last reviewed in April and incorporates objectives from the strategic plan. A new CEO was appointed on 5 July 2021 and a strategic for CHT is in progress. The performance and business plan for Waiuku April 2021, to March 2022 is completed but awaiting board approval. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager and the clinical coordinator have completed in excess of eight hours of professional development in the past year.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the temporary absence of the facility manager the clinical coordinator will provide management oversight of the facility with the support of the area manager.</p>
<p>Standard 1.2.3: Quality And</p>	<p>FA</p>	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans</p>

<p><b>Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>for CHT Waiuku. There is evidence that the quality system continues to be implemented at the service. The performance plan for the facility includes quality goals (strategic themes) with associated actions, milestones and dates achieved. 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. New/updated policies are sent from head office. Staff have access to file vision manuals and are alerted to changes via a weekly newsletter which is emailed to all staff and posted in the staff room.</p> <p>The unit manager advised that she is responsible for providing oversight of the quality programme. Interviews with the managers and staff and review of meetings including monthly registered nurse meetings and three-monthly quality/health and safety meeting minutes confirmed that quality systems developed by CHT are being implemented. A comprehensive internal audit that covers all aspects of the service against the health and disability sector standards is completed at least six-monthly by the area manager (January and May 2021). Other audits including infection control, restraint, environment health and safety are also completed as per the internal audit schedule.</p> <p>A range of data (e.g., falls, skin tears, pressure injuries, infections, property incidents, complaints, medication errors) are collected, collated and analysed at head office. The data is analysed, and trends are identified. Monthly comparisons including benchmarking against other CHT facilities include trend analysis and graphs. Areas of non-compliance identified through quality activities are actioned for improvement. Results are discussed in the three-monthly quality/health and staff meetings and monthly RN meeting. Minutes and quality data graphs are posted in the staffroom for staff who did not attend to read.</p> <p>Clinical meetings are held monthly and minutes report discussion around falls prevention, continence, wound care, weight, nutrition (REAP), restraint and infection control Restraint and enabler use is reported within the quality meetings. Interviews with staff confirmed that quality data is discussed at bimonthly staff meetings and the three-monthly quality health and safety staff meeting.</p> <p>Resident/relative meetings are held monthly, and a quarterly newsletter is sent to all family and residents. Residents and families are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Resident satisfaction surveys are regularly sent to residents and family. Survey results are collated, trended and analysed and results are shared with staff and family at meetings and minuted. Overall, all areas reported high levels of satisfaction. No trends were identified The UC stated Corrective actions would be implemented if concerns were identified. Interview with family confirmed that individual concerns and opportunities for improvement are addressed.</p> <p>There are risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety representatives include HCA's and a RN. All representatives have had external training related to their roles. The hazard register was up to date and is regularly monitored by the health and safety officer. Contractors are orientated to health and safety</p>
--	---

		<p>processes</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Strategies are in place to reduce the number of residents' falls. All new residents and residents who have experienced a fall are assessed by a physiotherapist and individual plans to minimise future falls are implemented. Sensor mats are used for those residents who are at risk of falling.</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>The service collects incident and accident data on forms, which are collated monthly and are discussed at the staff meetings, quality and health and safety meetings.</p> <p>Fifteen incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical coordinator collects incident forms, investigates and reviews, and implements corrective actions as required.</p> <p>The unit manager interviewed could describe situations that would require reporting to relevant authorities. There have been eleven section 31 reports to the Ministry of Health since the previous audit for occasions where it was not possible to provide onsite RN roster cover. An infectious outbreak was reported to the local DHB in April 21.</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>Human resources policies cover recruitment, selection, orientation and staff training and development. Eight staff files reviewed (two RNs, one clinical coordinator, one activities coordinator/HCA and four healthcare assistants) reflected evidence of reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Orientation is specific to the individual's job role and responsibilities. Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Training is primarily online with competency assessments linked to training. A register for each training session and an individual staff member record of training was verified. Additional training had included Covid-19 (infection control, personal protective equipment), EPOA and advance directive training, early identification of CVA's, and effective monitoring of the acutely unwell resident for registered staff.</p>

		<p>Registered nurses are supported to maintain their professional competency. Seven of the eight registered nurses have completed their interRAI training. The unit manager and clinical coordinator attend monthly management meetings which include an education component relevant to managing an aged care facility. Registered nurses are able to attend external training including sessions provided by the local DHB. An HCA and RN working as Health and Safety representatives, both have completed relevant external training. The service encourages Careerforce qualifications for staff. The majority of the 36 HCA's have level 3 or level 4 Careerforce qualifications.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy is in place to determine staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The unit manager and clinical coordinator are on duty during the day Monday to Friday. At present the Unit Manager has responsibility for all call but once the clinical coordinator completes orientation, the responsibility will be shared. It is envisaged both share the on-call requirement for clinical concerns on a rotational basis.</p> <p>The facility has five wings. Healthcare assistants are allocated responsibilities on the day.</p> <p>Across the facility, there are two RN's working morning shifts (both long shifts) and two RNs on afternoon shift (2 long) and one RN on night shift.</p> <p>There are four part time activity coordinators covering for Monday to Saturday ( one five hours shift and one three hours shift for Monday to Friday and one five hours on Saturday). The service is advertising for staff to cover Sunday activities There are three HCA's and one RN on night shift across the facility.</p> <p>Edgewater – 19 beds (13 hospital and four rest home residents)</p> <ul style="list-style-type: none"> <li>• AM shift - 3 HCA's (one long shift, two short)</li> <li>• PM shift – 1 HCA's (one long shift) and 1 HCA floater 3pm – 8pm between Edgewater and Portside</li> </ul> <p>Bayview - 10 beds (9 hospital and one rest home resident)</p> <ul style="list-style-type: none"> <li>• AM shift - 2 HCA's (one long, one short shift shared with Sandspit)</li> <li>• PM shift – 1 HCA (one long shift) and 1 HCA floater 3pm – 8pm between Sandspit and Riverside)</li> </ul> <p>Sandspit – 10 beds (6 hospital residents and 4 rest home residents)</p> <ul style="list-style-type: none"> <li>• AM shift - 2 HCA's (one long shift, one short shared with Bayview)</li> <li>• PM shift – 1 HCA (one long shift) and 1 HCA floater 3pm – 8pm between Sandspit and Riverside)</li> </ul> <p>Riverside- 10 beds (8 hospital residents and 2 rest home residents)</p>

		<ul style="list-style-type: none"> <li>• AM shift - 1 HCA's (one long, one short shift shared with Portside)</li> <li>• PM shift – 1 HCA (one long shift) and 1 HCA floater 3pm – 8pm between Sandspit and Bayview Portside – 11 beds (9 hospital and two rest home residents)</li> <li>• AM shift - 1 HCA's (one long shift, one short shared with Riverside)</li> <li>• PM shift – 1 HCA (one long shift and one short shift shared with Edgewater)</li> </ul> <p>At the time of the audit acuity was reported to be evenly spread throughout the facility. Management report staffing can be flexible to cover changes in acuity. There are experienced and long serving health care assistants who assist as able to cover for unexpected leave. Staff state they feel supported by the management team who respond quickly to after hour calls however on interview raised concerns with staffing levels at times. Interviews with management identified ongoing difficulty with recruitment of both HCA's and RN's. Agency staff are reluctant to travel to the facility further increasing roster resource issues. Residents and family members stated that staffing is adequate to meet the needs of residents. The GP commented that there are insufficient staff on the floor and raised concerned with turnover and loss of experienced RN's. On interview, the unit manager confirmed recent discussions with head office to increase rostered shift allocations. A roster review and increased allocation of staffing hours was confirmed on the day of audit. Four new HCA 's and two new RN's have been employed and commence over the next two weeks</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Resident files are held both electronically and in files and are protected from unauthorised access. Entries are computerised, dated, and include the relevant care giver or nurse including their designation. Individual resident files demonstrated service integration. Informed consent to display photographs is obtained from residents/family/whānau on admission. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The unit manager and clinical coordinator screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau 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,</p>

services has been identified.		<p>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 state that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members report that the unit manager or clinical coordinator are available to answer any questions regarding the admission process.</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 for an infection. All appropriate documentation and communication had been completed. Transfer to the hospital and back to the facility post-discharge, was 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 guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit, who had been assessed as competent to self-administer by the RN and GP. The resident's room was visited and confirmation that the medications were stored securely was obtained. 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 medication management 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 healthcare assistants 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 temperatures are checked daily and were within expected ranges. Eye drops are dated once opened.</p> <p>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	FA	Food services are outsourced to a contractor. The chef oversees the procurement of the food and

<p><b>Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>management of the kitchen. The chef is supported by a second chef, cooks and kitchen assistants. All staff have been trained in food safety and chemical safety. All meals are cooked on site and served in the main dining room adjacent to the kitchen with hotboxes utilised for tray service as required. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring January 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>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 using an electronic management system. Food temperatures are checked at all meals. These are all within safe limits. 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, and colour coded to aid staff in dietary requirement recognition. The four-weekly seasonal menu cycle is written and approved by an external dietitian. All resident/families interviewed are happy with the meals. Additional snacks are available at all times.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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	<p>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/whanau 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.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>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 for all long-term residents' files reviewed (excluding ACC and POAC).</p> <p>Resident files reviewed identify 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 general practitioner interviewed was 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 which are updated at least two-weekly. Wounds included five chronic wounds, six skin tears, one surgical wound and one dermatitis. There was also one grade 1 pressure injury (facility acquired). There was documented evidence of wound nurse specialist involvement in chronic wound management.</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 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 are four part-time activity coordinators covering Monday to Saturday between them who plan and lead all activities. The service is currently recruiting for an additional activities coordinator so it can offer a seven day per week activities programme. Residents were observed participating in planned activities during the time of audit.</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, men's group, pet therapy, knitting group, gardening group 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</p>

		<p>need, have a chat and are offered individual activities including pampering sessions.</p> <p>There are fortnightly outings, and the service utilises a contracted wheelchair accessible minibus 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, in addition to their being a monthly theme set by CHT head office. Examples of this include an Olympic, or Indian theme, with associated posters, decorations and resources being supplied by head office. There are visiting community groups such as cultural dance groups, churches and children's groups, and also one-off events such as a mouth painting demonstration by a local artist.</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 very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six of the eight resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. This number excluded the short-term POAC resident and a recent admission to the rest home. There is evidence of resident and family involvement in the review of long-term resident care plans against resident goals.</p> <p>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) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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 registered nurses 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 identifies that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</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. Sharp's containers are available and meet the hazardous substances regulations for containers. The</p>

<p>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>		<p>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>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires September 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 and paved areas are well maintained. All external areas have attractive features, included views of the nearby estuary and are easily accessible to residents. 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 hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mixture of rooms with ensuites, and those using communal facilities. There are 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. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings and wall coverings are 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>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	<p>FA</p>	<p>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>

consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas, including the main lounge and dining rooms in the Harbour wing and smaller combined lounge/dining areas in the Riverside and Bayview areas. Activities occur in all areas, 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>
<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	<p>All laundry is outsourced. There is a separate 'dirty' area for linen/clothing awaiting collection and a 'clean' area 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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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, radio and batteries), emergency power and barbeque. The facility keeps more than the 3 litres per resident per day of emergency water for resident use on site. The service has its own generator on site in case of power outage.</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>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated that this is effective. There is a monitored outdoor area</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>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>	<p>FA</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control resource nurse is an RN who is responsible for infection control across the facility as detailed in the resource nurse job description (signed copy sighted on day of audit). The resource nurse oversees infection control for the facility, reviews incidents on the electronic resident management system and is responsible for the collation of monthly infection events and reports. CHT head office are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and staff have received both doses of the Pfizer Covid-19 vaccine (one long-term resident declined). Residents and staff are offered the influenza vaccine. There has been one outbreak (scabies) since the last audit, which was managed appropriately.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE. During Covid lockdown staff were not allowed to travel to and from the facility in uniform. A changing area was provided, and all uniforms were laundered on site. Although this is no longer mandatory, staff are strongly encouraged to continue this practice.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at CHT Waiuku. The resource nurse liaises with the infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The resource nurse has completed annual training in infection control. External resources and support are available through the CHT area manager, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by CHT head office and subject to a monthly review meeting with the area manager.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</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</p>

<p>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>the principles of infection control. The policies have been developed by a CHT infection control specialist.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p> <p>The resource nurse 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 resource nurse 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 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>FA</p>	<p>Surveillance is an integral part of the infection control programme, and the purpose and methodology are described in the CHT surveillance policy. The infection control resource nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the quality/health and safety and infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database (Vcare) for benchmarking. Corrective actions are established where trends are identified.</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>Policies and procedures include definition of restraint and enabler that Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are congruent with the definition in NZS 8134.0, are comprehensive and include processes and use of restraints and enablers. Restraint is a standard agenda item on clinical and clinical meetings. The restraint coordinator is an RN.</p> <p>On the day of the audit there were two residents with restraints in use (lap belts) and one resident using bed rails as an enabler. The resident file was reviewed for enabler use and identified the resident had given voluntary consent.</p> <p>Staff education on RMSP/enablers has been provided. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A registered nurse is the restraint coordinator with a defined job description. Restraint discussion and quality data around restraint and enabler use is included in the quality/risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, the resident and their family/whānau undertakes assessments. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form had been completed for two resident files reviewed requiring restraint (sighted). Assessments identify risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is</p>

<p>Services use restraint safely</p>		<p>responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals, depending on individual risk to that resident.</p> <p>Restraint use is recorded in the care plan; with risks and cares to be carried out during the restraint episode documented. Individual restraint monitoring forms evidence that checks and cares have been carried out according to the documented frequency described in the monitoring tool. There is an up-to-date restraint register.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluations occur six-monthly as part of the ongoing review for residents on the restraint register, and as part of their care plan review. Families (where possible) and the GP and RNs are included as part of this review.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint usage is monitored regularly. The review of restraint use is discussed at the quality risk meetings and relevant facility meetings. The facility is proactive in minimising restraint with evidence of continued reduction over the last year. Internal restraint audits are completed six monthly and demonstrate compliance of the standard.</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.

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.