

# CHT Healthcare Trust - CHT Acacia

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	CHT Healthcare Trust	
<b>Premises audited:</b>	CHT Acacia	
<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: 13 October 2021	End date: 13 October 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>	56	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

CHT Acacia Park is part of the CHT group of facilities. The facility is a new two-storey purpose-built facility with the last stage completed in April 2021. The service cares for up to 61 residents requiring hospital and rest home level care. On the day of the audit, there were 56 residents.

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

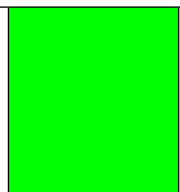
A unit manager, who is well qualified and experienced for the role oversees the service and is supported by a clinical coordinator and the area manager. Residents, relatives, and the GP interviewed spoke positively about the service provided.

The service continues to implement a quality and risk management system.

All three shortfalls from their previous partial provisional audit related to the completion of the medication room, courtyard and fire evacuation scheme have been addressed.


This audit confirmed that the improvements required are related to the code of compliance for the new building and safe storage of chemicals.

## 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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Communication with residents and families is appropriately managed. Families are regularly updated of residents' condition including any acute changes or incidents. Residents and family member interviewed verified ongoing involvement with the community. Complaints processes are implemented and managed in line with the Code.

## Organisational management

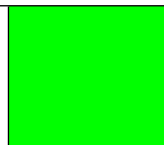
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There are annual quality goals for the service that are regularly reviewed. There is a documented quality and risk management system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents and accidents are reported and appropriately managed. Residents and relatives are provided the opportunity to feedback on service delivery issues at three-monthly resident meetings and via annual satisfaction surveys.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. 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.



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 and hospital level 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, are provided, and nutritious snacks are available 24 hours per day.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has a current certificate of public use. There is adequate room for residents to move freely about the home using mobility aids. Outdoor areas are safe and accessible for the residents and shade is provided. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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CHT Acacia has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents on restraint and no residents with an enabler. Restraint management processes are adhered to.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme includes 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 have been no outbreaks since the last audit.

## 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	16	0	1	1	0	0
<b>Criteria</b>	0	46	0	1	1	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
<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 the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. The unit manager receives any complaints, and these are investigated in consultation with the clinical coordinator.</p> <p>Verbal, written and email complaints are documented, acknowledged, and investigated within Health and Disability Commissioner (HDC) timeframes. There was evidence of written responses, corrective actions and meetings including follow-up meetings and phone calls to ensure the complainant was satisfied with the outcome. An electronic complaints' register is maintained.</p> <p>There had been one HDC complaint in October 2019 and it is still under investigation. The latest letter received from HDC dated 14 September 2021 requested comments related to staff training. The service has implemented a range of training and education sessions to improve the service.</p> <p>There have been twenty-two internal complaints between July 2019 and September 2021 which have been resolved. There is one recent complaint which has been investigated and addressed but not yet closed off due to further legal advice being sought.</p> <p>Complaints received and corrective actions are discussed in the monthly quality meetings. Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the registered nurses ( RNs) and management team.</p>

		Thirteen staff interviewed (seven healthcare assistants [HCAs] including the health and safety officer, three registered nurses [RNs] and one enrolled nurse [EN], kitchen assistant and chef) could explain the complaints process and responsibilities.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Four residents interviewed (two rest home and two hospital) and two family members (one hospital and one rest home) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents reviewed identified the relative had been notified. Relatives were required to make an appointment on the days of audit prior to visiting because of the level of lock down related to the Covid 19 pandemic. Therefore the relative interview numbers were low.  Resident and family meetings will commence post Covid-19 lockdown (the audit was conducted during alert level two). Minutes sighted evidenced discussion around all services including information related to Covid-19. Residents interviewed stated the staff and management are very approachable. There is access to interpreters as required.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	CHT Acacia Park provides care for up to 61 residents requiring rest home, and hospital level care (geriatric or medical). All rooms are dual-purpose with one double room downstairs. On the day of the audit there were 56 residents (28 rest home and 28 hospital). All residents were under the ARCC contract except one on end-of-life contract (EOL) and one on a younger person with disability (YPD).  The new building is purpose built. Stage three of the new building had been completed in April 2021 which included demolishing what remains of the old building and included a new laundry, offices, reception, nurses, and treatment rooms.  CHT has a documented philosophy of care, mission statement and overall business/strategic plan. The CHT Business plan includes a risk management plan. An area manager completes a monthly milestone report to the board which provides the link between governance and service level. There is a monthly quality report across all sites. The unit manager and clinical coordinator meet monthly with other CHT managers in the area and go through the KPIs with the CEO. There are also monthly unit review meetings held with the area manager. The unit manager's performance plan identifies business and quality goals for the current year. These goals are regularly reviewed and signed off when achieved.  Three managers were interviewed during the audit. They were the unit manager, clinical coordinator, and area manager. The unit manager is a registered nurse who maintains an annual practicing certificate. The unit manager has over 20 years' experience in aged care and was in the clinical coordinator role at Acacia prior to taking on the unit manager role in 2016. The manager is supported by the clinical coordinator who has been in the role since June 2021 and has over nine years' experience in aged care and a similar role. The unit manager reports to an area manager on a regular basis (minimum of monthly). All managers and the clinical coordinator have completed at

		least eight hours of professional development along with management training.
<p><b>Standard 1.2.3: Quality And 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>	FA	<p>There is a unit business/strategic plan that includes quality goals and risk management plans. The unit manager provides oversight of the quality programme and provides monthly reports to the area manager and head office. The quality and risk management programme is designed to monitor contractual and standards compliance.</p> <p>A document control system is in place with all quality documents reviewed by area managers. New policies or changes to policy are sent to the unit and communicated to staff via meetings and their individual emails. Staff have access to the electronic “file vision” documents including policies and procedures.</p> <p>Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints, and internal audit outcomes. Organisational benchmarking occurs and quality improvements developed where results are less than expected. Staff interviewed confirmed they are kept informed on quality data, trends and corrective actions at the quarterly combined quality/health and safety meetings, general facility meetings and RN meetings. Copies of minutes are posted in the staff room.</p> <p>The area manager completes six-monthly internal audits against core standards, restraint, and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off by the unit manager when completed.</p> <p>Annual resident/relative surveys have been completed for 2020 and 2021. The results have been collated at head office and fed back to the service. A corrective action plan for 2020 and 2021 was sighted for areas requiring improvement. The quality improvements are linked to the unit quality plan and monitored for progress against identified goals. There were no immediate areas identified for improvement.</p> <p>The service has a health and safety programme in place. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is included in the quarterly combined quality/health and safety/infection control meetings. The health and safety representative/HCA (interviewed) has completed health and safety training in September 2020. The health and safety representative confirmed staff were observant and promptly reported any hazards, unsafe situations, and faulty equipment. There is a current hazard register in place. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling (taken by the physiotherapist). There have been contractors on site since January 2020 (except during lockdown) and the health and safety representative stated the staff had been kept informed on building progress and potential hazards. There were regular meetings with the contractors. On the day of audit, the main entrance and one corridor was safely cordoned off while the last six rooms were being refurbished. There was a temporary main entrance and a contractor’s hazard board in place.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The physiotherapist completes mobility assessments for residents on admission, post falls and six-</p>

		<p>monthly reviews and sees residents as required.</p> <p>There is adequate transferring equipment available, sensor mats and transfer plans in resident rooms identify the residents falls risk.</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>Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. CHT has recently introduced external benchmarking.</p> <p>Ten resident related incident reports for September were reviewed. Incident forms are completed on the electronic system, reviewed by the RN and corrective/preventative actions monitored by the clinical coordinator. The clinical coordinator reviews the data on the electronic system which collates events. Monthly reports are analysed for trends, corrective actions and discussed at the quality/health and safety/infection control meeting and other facility meetings. All events have a checklist completed which includes notification of the relatives. Neurological observations were commenced for unwitnessed falls where the resident could not state if they hit their head or if there was a potential head injury. Documentation including care plan interventions for falls prevention were fully documented.</p> <p>There is an accidents and incidents reporting policy. There is a discussion of incidents/accidents at quality/health and safety, clinical meetings, and handovers, including actions to minimise recurrence. Staff interviewed confirmed incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been four Section 31 notifications since the previous audit including three related to a missing person, and one to notify of the change in clinical coordinator (June 2021). There were no stage three or greater pressure injuries requiring a section 31 notification or outbreaks since the last audit.</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</p>	FA	<p>There are human resources policies to support recruitment practices including relevant checks to validate the individual's qualifications, experience, and veracity. Five staff files reviewed (one clinical coordinator, one RN, two healthcare assistants and one activity coordinator) contained all relevant employment documentation and job descriptions. Current practising certificates were sighted for the RNs, and allied health professionals. All staff sign a code of conduct, code of confidentiality and information technology policy. Performance appraisals were up to date.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>The service uses the Altura online training. The Altura education planner covers the compulsory education requirements. There are additional onsite clinical in-services held by external trainers/speakers such as hospice, chemical provider, physiotherapist, and residential aged care nurse specialist.</p>

<p>legislation.</p>		<p>The RNs have an opportunity to attend DHB education days as offered. Eight of the nine RNs and one EN have completed interRAI training.</p> <p>There are 37 HCAs and 25 have completed level three and four. The clinical coordinator is supporting three HCAs through their Careerforce papers. The HCAs interviewed feel well supported to attend education opportunities.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>CHT organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. The unit manager and clinical coordinator work fulltime Monday to Friday and share the on call 24/7. There is a casual pool of staff whose hours were increased to assist during the Covid-19 lockdown. The service uses a preferred bureau for RN cover as needed.</p> <p>Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. The registered nurse on each shift is aware that staff working short shifts can be extended to meet increased resident needs.</p> <p>There is one roster, but colour coded to indicate the allocation of staff to different wings. This is done at handover. RNs assist HCAs on the floor with activities of daily living.</p> <p>NIGHT: There is one night RN with three HCAs for support during the night. There are medication competent HCAs on each shift to support the RN and at least one staff member with a first aid certificate.</p> <p>The facility is divided into six pods: Upstairs 30 beds (i) Matakana (ii) Motuhoai, (iii) Kamai; and downstairs 31 beds including one double room with single occupancy (i) Pahoia, ii) Waitui and iii) Kotuku.</p> <p>There are 27 resident's downstairs. There were 15 hospital level residents including palliative care and YPD and 12 rest home residents.</p> <p>AM RN 6.45-3pm and supported by HCA (x2) 7am-3pm; HCA (x2)7am-12 noon</p> <p>PM RN 2.45-11.15pm and supported by 3 HCAs working 3pm-11pm</p> <p>There were 29 residents upstairs including 13 hospital level residents and 16 requiring rest home level of care.</p> <p>AM RN 6.45-3pm and supported by HCA (x2) 7am-3pm; HCA (x2)7am-12 noon</p> <p>Another HCA in the morning is working 7am-3pm and is medication competent and float to assist between the floors.</p> <p>PM RN 2.45pm-11.15pm and supported by 2 HCAs and a floater (3 pm-8 pm or 4 pm-8 pm).</p> <p>There are separate staff allocated to the kitchen, laundry, housekeeping, maintenance and groundskeeping.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>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. There are no standing orders in use. There are no vaccines stored on site. All clinical staff (RNs, EN and med-comp HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and HCAs interviewed could describe their role regarding medication administration.</p> <p>The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart (medimap) and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily and were within acceptable ranges. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</p> <p>The treatment room located downstairs has been completed as part of stage three of the build and this is secure. The improvement required identified at the partial provisional audit has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals at CHT Acacia are all prepared and cooked on site by an outsourced contracted provider. The kitchen was observed to be clean, well-organised and a current approved food control plan was in evidence. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the servery. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. There is a food control plan expiring 7 April 2022.</p> <p>The residents interviewed were satisfied with the food service and the variety and choice of meals provided. They</p>

		can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.
<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>	FA	<p>The registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents' mobility and transfer needs as required.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both a paper-based wound log and the VCare system. There were 19 ongoing wounds including nine lesions, two chronic ulcers, one sinus, four skin tears, two BCC and one stage 1 pressure injury (facility acquired). There service has access to a wound nurse specialist for input and advice as required, and this was in evidence with the chronic wounds.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food, and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.</p> <p>Care plans have been updated as residents' needs changed.</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</p>	FA	<p>There are two activity coordinators and an afternoon activities assistant who provide a seven-day programme across both care levels. A company diversional therapist (DT) oversees the activity programmes. The activity coordinators attend CHT workshops and on-site in-services. All hold current first aid certificates.</p> <p>The programme is planned monthly and includes CHT minimum requirements for the activities programme, including themed cultural events. Activities programmes are displayed on noticeboards around the facility and a weekly calendar is delivered to each individual resident. Activities are delivered to meet the cognitive, physical, intellectual, and emotional needs of the residents. One-on-one time is spent with residents who are unable to</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>actively participate in the activities.</p> <p>Entertainment and outings are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed. The YPD file reviewed showed evidence of how community links are maintained within the individual activities plan. The YPD resident was unable to be interviewed on the day of the audit.</p> <p>An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment, and outings. Resident meetings are held three monthly and family are invited to attend. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents and relatives interviewed spoke positively about the activity programme provided.</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 evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Four long-term care files sampled of permanent residents contained written evaluations completed six-monthly, with the fifth file being a new admission. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during</p>	<p>PA Moderate</p>	<p>The service has policies and procedures for the disposal of waste and hazardous material. There is an incident system for investigating, recording, and reporting all incidents. The chemicals supplies are kept in locked cupboards in service areas. A chemical spills kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (gloves, aprons, goggles) are readily available to staff and reusable items are included in the cleaning policies. Chemicals are not securely stored.</p>



service delivery.		
<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>	PA Low	<p>Stage three of the build was completed in April 2021.</p> <p>There are 31 beds (including a double toom) upstairs and 30 beds downstairs. There is a lift situated in the reception area and fitted with an emergency call bell.</p> <p>There are three pods of ten bedrooms with a communal lounge/dining room/kitchenette in each pod upstairs and three similar pods downstairs to a total of 31 beds. There are walkways around the building with a well-maintained courtyard.</p> <p>There is a current certificate of public use. A code of compliance is yet to be obtained for stage three which is the final stage of the new build. The agent (visited on the day of the audit) confirmed the required documentation and records of work are in the process of submission. The code of compliance for stage two was not issued but the current certificate of public use has been reissued in July 2021. The improvement identified at the partial provisional is still required and will now require including stage two and three.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. The facility has a vehicle available for transportation of residents, with a current warrant of fitness and registration. Those staff transporting residents hold a current first aid certificate.</p> <p>The HCAs and registered nurses stated they have enough equipment to safely deliver the cares as outlined in the resident care plans. There are adequate storage areas for hoist, wheelchairs, products, and other equipment. There is a designated external smoking area.</p> <p>The organisation has purchased new equipment and all other equipment has been calibrated, tested, and tagged where required. Equipment and medical equipment calibration and servicing is captured within the quality programme and scheduled annually.</p> <p>Policies relating to provision of equipment, furniture and amenities are documented including maintenance and cleaning.</p> <p>The pathways and concrete patios around the current building have been completed and allow residents to be able to access outdoor areas and the existing building and roadway easily. The courtyard including landscaping around the stage two-part building has been completed and the improvement required at the partial provisional audit has now been addressed.</p>
Standard 1.4.7: Essential,	FA	The emergency and disaster manual includes dealing with emergencies and disasters, essential locations, internal emergencies, and external emergencies. Emergencies, first aid and CPR are included in the mandatory in-services

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>programme and the annual training plan includes emergency training. First aid training for staff is always in place with a registered nurse on duty with a current first aid certificate.</p> <p>An orientation to the new building has been completed for all staff including a fire drill following the approval of the evacuation scheme on 19 May 2021. The requirements identified at the partial provisional related to the fire evacuation scheme has now been met.</p> <p>The new building has alternative power systems in place to be able to cook in the event of a power failure. A generator is available onsite if needed. There is a civil defence kit for the whole facility and drinkable water is stored in large holding tanks. The volume of stored water for emergencies meets civil defence guidelines. A civil defence folder includes procedures specific to the facility and organisation.</p> <p>The call bell system was sighted in all bedrooms, ensuites and communal areas and lift. There are call bell panels and phones in the hallways.</p> <p>The doors of the building can be locked, and security is relevant to the needs of the residents and staff with checks by staff prior to dusk. External doors can be locked for security. All ranch sliders off resident rooms are linked to the alarm system. All external doors are lockable and security procedures are in place. Emergency equipment including egress, sprinkler systems, smoke detectors are part of the monthly checks completed by an agent.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance programme is organised and promoted centrally from CHT head office. Effective monitoring is the responsibility of the infection control coordinator (RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the RN and staff meetings.</p> <p>The overall effectiveness of the surveillance programme is evaluated annually by the CHT infection control committee. All meetings held at CHT Acacia include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and are analysed at site level using VCare.</p> <p>An organisational Covid-19 strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE, and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE; these details being passed on to families via email, telephone and in writing. During Covid lockdown the service implemented weekly staff briefings which allowed for updates, education, and discussion. All visitors are required to sign in, provide contact tracing information and have their temperature taken upon entry. Visiting during the current level 2 is by appointment and staff are still strongly encouraged not to travel to and from work in uniform, having changing facilities provided on site.</p> <p>There have been no outbreaks since the last audit.</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>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents with restraints, and no enablers in use.</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 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Moderate	During visual inspection (morning and afternoon) of both sluice rooms (upstairs and downstairs) there were cleaning trolleys with chemicals stored in the sluice room. The downstairs sluice room had bulk storage of chemicals stored on the floor. There was no keypad access on the doors and the clinical coordinator interviewed confirmed doors are kept unlocked.	Chemicals were not stored in a safe and secure manner.	<p>Ensure safe and secure storage of all chemicals.</p> <p>60 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	The building has a certificate for public use to include a stage four (drainage requirements). This was reissued in July 2021 and will expire in October 2021. The area manager and unit manager interviewed stated the building has now been completed including stage four. The agent visited the facility on the day of the audit and	There was not yet a code of compliance issued to	Ensure a code of compliance is obtained.

		confirmed the required documentation is in the process of submission for application of the code of compliance.	include stage two and three of the new build.	60 days
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.