

# CHT Healthcare Trust - Carnarvon Private Hospital

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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>	Carnarvon Private Hospital	
<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: 8 February 2022	End date: 8 February 2022
<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>	52	

# 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 Carnarvon is part of the CHT group of facilities. The service provides hospital and rest home level care for up to 60 residents. On the day of audit there were 52 residents.

This unannounced surveillance audit was conducted against a subset of the 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 residents and staff files, observations and interviews with residents, family, management, and staff.

The residents, relatives and general practitioner spoke highly of the care and service provided. The service has a well-established quality system that identifies ongoing quality improvement.

The previous certification audit shortfall related to implementation of care has been addressed. The environmental shortfalls related to the previous partial provisional audit have been addressed.

This audit identified two shortfalls around complaints management and medication documentation.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. A complaint register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. The general manager is responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded into practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff includes in-service and online education and training. Registered nursing cover is provided seven days a week, twenty-four hours a day. Residents and families report that staffing levels are adequate to meet the needs of the residents. The integrated residents' files are appropriate to the service type.

## Continuum of service delivery

<p>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.</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's policies and procedures provide documented guidelines for access and entry to the service. All residents are assessed before entry to the service to confirm their level of care. The nursing team is responsible for all assessments, care planning, and evaluation of service delivery plans. Care plans are individualised and based on the residents' assessed needs and basic routines. Interventions developed are appropriate and evaluated within the recommended time frames. The ongoing evaluation process ensures that assessments reflect the residents' status.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with nominated family member representatives, including all residents' activities of interest. In interviews, residents and family/whānau expressed satisfaction with how activities are conducted at the service and the activities programme in place.

There is a medicine management system in place. All medications are reviewed by the general practitioner (GP) every three months. Staff involved in medication administration have current medication competencies.

The food service provides for specific dietary likes and dislikes of the residents. Nutritional requirements are met.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current code of compliance in place. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. All areas are accessible to people with a disability. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had one resident assessed as requiring the use of restraint and four residents assessed as requiring an enabler. Staff regularly receive education and training in restraint minimisation and safe practice.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There has been no outbreaks since the previous audit. adequate supplies of personal protective equipment were sighted during the 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	15	0	1	1	0	0
<b>Criteria</b>	0	41	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>	PA Low	<p>The service has a complaints policy that describes the management of complaints process. Complaints forms are available at reception. Information about complaints is provided on admission in the services guide. Interviews with residents and relatives demonstrated their understanding of the complaints process. Staff interviewed including: three health care assistants (HCAs), one clinical coordinator, one registered nurse (RN), a housekeeper, an activity person and a maintenance person were able to describe the process around reporting complaints.</p> <p>There is a complaint register that contains details for each lodged formal complaint. Informal complaints are followed up through resident meetings; these meetings have not always occurred and there is no log of informal or 'lower level' complaints. Families and residents interviewed felt that not all complaints were followed up.</p> <p>There were two complaints on the complaint log, both were Health and Disability Complaints. Both documented a comprehensive investigation and full response to the Health and Disability Commissioner.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Relatives interviewed (one hospital level and one rest home) and residents interviewed (five rest home level and five hospital) stated they were welcomed on entry and given time and explanation about the services and procedures. There is an interpreter policy in place and contact details of interpreters are available. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed, and all of the completed forms indicated family were informed about the event. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>CHT Carnarvon is owned and operated by CHT Healthcare Trust. The service provides rest home and hospital level care for up to 60 residents. On the day of the audit, there were five rest home level and 47 hospital level residents. This included one hospital level resident on a younger person with disability (YPD) contract, one hospital level ACC, one hospital level palliative resident and one hospital level respite resident. The remaining residents were on the aged related residential care (ARRC) contract. Four rooms are designated as rest home only and the remaining rooms are designated as dual purpose.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. The unit manager has significant experience in DHB aged care services and management of the service since 2016. Support for clinical leadership is provided by the clinical coordinator and competent registered nurses. The unit manager reports to the CHT area manager weekly on a variety of operational issues.</p> <p>CHT has an overall business/strategic plan and Carnarvon Hospital has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The unit manager has completed more than eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The performance plan for the facility includes quality goals (strategic themes) with associated actions, milestones and dates achieved. The unit manager continues to provide oversight of the quality programme. Interviews with staff confirmed their familiarity with the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed and updated at the organisational level. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes.</p> <p>Data continues to be collected in relation to a variety of quality activities and a comprehensive internal audit has been implemented. Data is collected around operational and clinical areas of the business including accidents, incidents, complaints, infections, restraint use, and feedback on the customer experience. Benchmarking reports are provided quarterly, and the results discussed at the quarterly quality health and safety meetings as well as</p>

		<p>staff and RN meetings. The results of the customer experience survey showed that residents continue to be very satisfied with care provided.</p> <p>The service has a health and safety policy and process. Issues and concerns are addressed in the monthly quality/health and safety meetings. These are also discussed at the monthly staff meetings. Meetings have been less frequent over the Covid lockdown periods, however, there has been at least one meeting a month to continue discussions around all aspects of the quality and risk management programme and changes related to Covid. Resident/relative meetings have not been held regularly (link 1.1.13.1).</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy that is being implemented by the service.</p> <p>Ten accident/incident forms were randomly selected for review. A registered nurse conducts a clinical follow up of each adverse event. Neurological observations are completed for unwitnessed falls. All adverse events reviewed demonstrated that appropriate clinical follow up and investigation took place. Adverse events are also reviewed and signed off by the unit manager. Trends are identified at head office with data benchmarked against the other CHT facilities. This data is available electronically for managers to access.</p> <p>Discussion with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. Notifications have included two Health and Disability complaints</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience, and veracity. Copies of current practising certificates are retained. Five staff files (two RNs, two HCAs and one activities coordinator) reviewed evidenced implementation of the recruitment process, employment contracts and annual performance appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and remarked that new staff were adequately orientated to the service. Evidence of an orientation programme being completed was sighted in the staff files reviewed.</p> <p>There is an annual education plan that is being implemented that includes in-services and completion of online education modules. The competency programme is ongoing with different requirements according to work type. All HCAs are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. Currently</p>

		<p>there are six HCAs who have achieved level 4, nine who have completed level 3 and five who have completed level 2.</p> <p>The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Six of the six registered nurses employed have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The unit manager (a registered nurse) is on duty from Monday to Friday and on call.</p> <p>There are two RNs on the morning shift, two on the afternoon shift and one at night. Advised that extra staff can be called on for increased resident requirements.</p> <p>There is one roster and staff are allocated by the lead RN each shift. One the day of audit there were five residents at rest home level and 47 at hospital level.</p> <p>Morning shift: Ten healthcare assistants (five long shift and five on a short shift).</p> <p>Afternoon shift: Six healthcare assistants including one on a short shift.</p> <p>Night shift: One registered nurse and three healthcare assistants.</p> <p>The current staffing is sufficient to meet the needs of rest home and hospital level residents. Residents and family interviewed confirmed that there were sufficient staff on duty at any given time.</p>
<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>	PA Moderate	<p>The medication management policy identifies all aspects of medicine management as outlined in the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription, and these were updated in the electronic medication management system. The GP completes three monthly reviews.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy promptly. Medications were stored safely and securely in the trollies and locked treatment room. Medication competencies were completed annually for all staff administering medication. The CC reported that some medication-related audits are conducted as per the facility's internal audit schedule.</p> <p>There were no residents self-administering medications and there is a self-medication policy to guide staff in</p>

		<p>place when required.</p> <p>Nine of ten medication charts sampled evidenced inconsistent evaluation of the effectiveness of pro re nata (PRN) medicines administered. This included PRN medication prescribed for pain, sleeping, topical creams, and elimination, however, not all outcomes were documented consistently.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The kitchen service complies with current food safety legislation and guidelines. Meal services are outsourced to external food services. The service employs a chef who works Monday to Friday and a cook covering weekends. All kitchen staff have current food handling certificates. There is an approved food control plan for the service which expires on 7 April 2022. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian on 8 November 2021 to ensure it meets the recognised nutritional guidelines appropriate to the consumer group.</p> <p>Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a dietary information profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every month. Records of temperature monitoring of food, fridges, and freezers are maintained, and these are recorded in the (safe food pro) electronic record management system. Food is transported in hot cart boxes to the respective dining areas.</p> <p>The residents and family/whānau interviewed indicated satisfaction with the food service.</p> <p>All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</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>	FA	<p>All residents' files sampled evidenced that care plans developed had interventions that were relevant and are adequate to address the identified needs of residents.</p> <p>Any residents' changing needs were reported in a timely manner and prescribed orders were carried out. The CC reconfirmed that the GP's medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was further reiterated by the GP in the interview conducted. Care staff confirmed that care was provided as outlined in the care plan.</p> <p>All the previous corrective areas requiring improvement in relation to; wound care evaluations, pressure injury assessments, risks associated with warfarin use, identifying signs and symptoms of hypoglycaemia in long term</p>

		<p>care plans for residents with impaired glucose tolerance, monitoring of blood glucose levels, and documentation of resident's cultural needs during care planning process were addressed. Evidence was sighted in files reviewed.</p> <p>On the day of the audit, there were seven wounds including one stage 2 pressure injury. All had appropriate assessments, wound management plans and evaluations documented. There were adequate continence and wound supplies sighted and access to wound care and continence specialists through the DHB.</p> <p>A range of equipment and resources are available, suited to the level of care provided and following the residents' needs.</p> <p>there are a range of monitoring charts used including (but not limited to); turning charts, food intake and output, blood sugar monitoring, weight, and vital signs.</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>	FA	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by a qualified diversional therapist who is employed as an activities coordinator and is supported by an assistant activity coordinator. The activities programme is implemented from Monday to Sunday. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A resident lifestyle questionnaire is completed for each resident within two weeks of admission in consultation with the family.</p> <p>The activities are varied and appropriate for young people with disability and those assessed as requiring rest home and hospital level of care. Residents' activities care plans were evaluated every six months or when there was any significant change. Van trips are conducted once a week.</p> <p>Activities care-plans reflected residents' preferred activities of choice and are evaluated every six months or as necessary. Activity progress notes and activity attendance checklists were completed daily. The residents were observed participating in a variety of activities on the day of the audit. The monthly planner sighted included pet therapy, story reading, art, social van rides, exercises, board games, movies, music, happy hour, audio book reading, and a mobile tuckshop run by one of the residents. The activities coordinator reported that six volunteers come on different days of the week to assist with activities. The planned activities and community connections are suitable for the residents.</p> <p>Family members and residents reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p>	FA	<p>Resident care is documented on each shift by care staff and the nursing team in the progress notes. All noted changes by the health care assistants are appraised to the nursing team and interventions initiated promptly.</p> <p>Each resident's care plan and interRAI assessment is evaluated, reviewed, and amended either when clinically</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>indicated by a change in the resident's condition or at least every six months whichever is earlier. The evaluations reflected the achievement of the set goals over the previous six months. The evaluations are carried out by the RNs in conjunction with family, residents, GP, and specialist service providers.</p> <p>Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau are included and informed of all changes.</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>All previous areas requiring improvement outlined below were addressed. Evidence of this was sighted in documents reviewed and also during the tour of the facility. There is a current code of compliance that was issued on 10 May 2021. All furnishings, shelving, cabinetry, paint, and floorings have now been completed in the new wing. There is running hot water in the new wing and temperature monitoring is completed every month. The sighted recordings for 2021, up to date were within the recommended ranges. Communal bathrooms had locks and identification labels in place. The ensuite and communal toilet and bathroom facilities are currently in use and disability rails were installed.</p> <p>The maintenance man is responsible for all reactive and planned maintenance. There is a documented maintenance schedule in place. Hot water temperatures are recorded and were within safe ranges for the whole facility. All equipment has been tagged, tested, and calibrated.</p> <p>The inside and outside area was clean and well maintained. The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. There are ramps to enable disability access. Residents can walk around freely throughout the facility and grounds. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and that they are happy with the environment.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The following previous areas requiring improvement were all addressed. The facility has an approved evacuation plan, and an evacuation policy is in place. A fire drill takes place every six months and the most recent was conducted on 26 January 2022. All staff complete fire training and participate in a fire drill. Orientation for new employees includes emergency and security training. The call bell system is operational with bells in each room. Those tested on the day of the audit were working and staff responded to call bells promptly. Residents interviewed confirmed that staff attends promptly when a bell is activated. There are labels on the walls to indicate call bells. Staff demonstrated awareness of emergency procedures.</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 infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There have been no outbreaks.</p> <p>The service has prepared for Covid with training for staff, supplies of PPE and oxygen. All staff and visitors have daily temperature recording with a rapid antigen test if a temperature is elevated.</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 are congruent with the definition in NZS 8134.0. A registered nurse is the designated restraint coordinator. There was one resident with restraint and four residents with an enabler. The restraint was a lap-belt, and the enablers were either bedrails and/or a lap-belt.</p> <p>Two files were reviewed one restraint and one enabler. All necessary documentation had been completed in relation to the enabler and restraint including written consent for use by the residents.</p> <p>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. Staff education on RMSP/enablers has been provided. Restraint minimisation is regularly discussed in staff meetings.</p>



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>The service has a complaints policy that describes the management of complaints process. Complaints forms are available at reception. Information about complaints is provided on admission in the services guide. There is a documented complaints log for formal complaints and these complaints document comprehensive follow up. Informal and 'lower level' complaints are managed through the residents meeting. Resident meetings have not consistently been documented as occurring and meetings documented do not all document complaints. Residents and family interviewed did not feel all complaints were followed up</p>	<p>Informal complaints are not documented as followed up through resident meetings and as the complaints are not logged there is no avenue to review any complaint trends.</p>	<p>Ensure all complaints are documented and documented as followed up to the satisfaction of the complainant.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The RNs were observed administering medicines following the required medication protocol guidelines and legislative requirements. Monitoring of medicine fridge and room temperatures is conducted regularly and deviations from normal were reported and attended to promptly.</p> <p>PRN (as required) medicines administered to residents such as pain relief, laxatives, topical creams, and sleeping tablets were not being evaluated for effectiveness. This was evidenced in nine of ten medication charts sampled.</p>	<p>Outcomes of PRN medicines administered in nine out of 10 medication charts sampled were not consistently documented.</p>	<p>Ensure administered PRN medicines are evaluated for effectiveness.</p> <p>90 days</p>
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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.