

CHT Healthcare Trust - Lansdowne 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:

Legal entity:	CHT Healthcare Trust
Premises audited:	Lansdowne Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 February 2022 End date: 11 February 2022
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	87

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

CHT Lansdowne is owned and operated by the CHT Healthcare Trust and cares for up to 95 residents requiring rest home or hospital (geriatric and medical) level care.

On the day of the audit, there were 87 residents. The service is overseen by a unit manager who is qualified and experienced for the role and is supported by a clinical coordinator, area manager and stable workforce. Residents, relatives, and the nurse practitioner interviewed spoke positively about the service provided.

The service continues to embed the electronic resident management system.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management, and the nurse practitioner.

This audit has identified no areas for improvement. The service was awarded a continuous improvement for falls prevention strategies.

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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Policies and procedures adhere with the requirements under the Health and Disability Services Consumers' Rights (the Code). The information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. 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 in line with the facility's Covid-19 response framework.

There is an established system for the management of complaints.

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 unit 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 documented. 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 specific to the role 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 reported that staffing levels are adequate to meet the needs of the residents. The integrated electronic residents' files are appropriate to the service type.

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
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

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

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

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

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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The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to 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. An external contractor manages the cleaning and laundry services. 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.

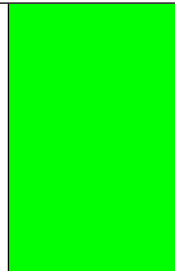
Restraint minimisation and safe practice

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 restraint coordinator is a registered nurse. The service had two residents assessed as requiring the use of restraint and three residents assessed as requiring an enabler. Staff regularly receive education and training in challenging behaviour and restraint minimisation and safe practice. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform service providers.

Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Covid-19 response framework and preparedness strategies are integrated as part of the overall infection control programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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. The organisation benchmark internally with their other facilities. There has been one respiratory outbreak 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)
Standards	0	50	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with nineteen staff (eight healthcare assistants, five registered nurses (RNs), two activities coordinators, one chef manager, kitchen assistant, one maintenance person and one cleaner) confirmed their familiarity with the Code and its application to their job role and responsibilities. Interviews with nine residents (six hospital level including one younger person with disability (YPD) and three rest home resident) and four relatives (three hospital level and one rest home) confirmed that the services being provided are in line with the Code. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. There is evidence of discussion with family when the GP completed a clinically</p>

<p>choices and give informed consent.</p>		<p>indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten of ten resident electronic and paper-based records sampled (four from the rest and six hospital) have a signed admission agreement and completed informed consent documentation including for the flu vaccine and Covid vaccine.</p>
<p>Standard 1.1.11: Advocacy and Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>A policy describes access to advocacy services and staff receive regular training on advocacy. Information about accessing advocacy services information is available in the information presented to residents and families at the time of entry to the service. Advocacy contact details are included on complaint forms and in complaint resolution letters. Advocate support is available if requested. Interviews with staff and residents confirmed that they are aware of the resident's right to advocacy services. Healthcare assistants interviewed confirmed that they help advocate for the residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents and family members interviewed confirmed that the service made an effort to maintain contact with relative/family members when visiting could not occur during certain times of the Covid-19 response framework. Community links were evident within the examples provided. Residents are assisted to maximise their potential for self-help and to maintain links with whānau and the community by supporting them to go out into the community. The younger person with disabilities (YPD) chooses activities they wish to participate in (if able); Wi-Fi is available to residents and they are encouraged to maintain their community links and normal routine. The activities programme includes entertainers and volunteers (when permitted).</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to HDC advocacy services. Information about complaints is provided on admission. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that is held by the unit manager. Fifteen complaints were recorded (three for 2021) since the previous audit, there were no complaints received year to date for 2022. Verbal and written complaints are documented in the electronic system. All complaints reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. All corrective actions are fed back to complainants in a timely manner. Complaints are trended at head office.</p> <p>One complaint dated January 2019 was resolved through the National Health and Disability Advocacy Service.</p> <p>Of the complaints reviewed, one complaint was lodged with the Health and Disability commissioner (May 2019) with a provisional decision received from HDC on 3 January 2022. The facility has time until 14 February 2022 to respond. The complaint remains open.</p> <p>Discussions with residents and families confirmed they understand the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code on display and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss.</p> <p>On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The resident pack includes a summary of information relating to the Code and a pamphlet</p>

		on the Code.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Policies align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their privacy needs were met and that they were treated with dignity and respect. The area manager is the privacy officer. Staff receive regular training around recognising abuse and neglect (August 2021).</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>	FA	<p>The service has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and involvement is encouraged. The service has links with the local Māori iwi for advice and support as required. There were three residents who identified as Māori at the time of the audit. Cultural needs were addressed in the residents' care plan and recognise the effect of any decision on the resident's relationship with their family, whānau, hapū, iwi, and family group and their links to whakapapa to be considered.</p> <p>Staff completes annual cultural awareness education. The service has established cultural policies to help meet the cultural needs of its residents.</p> <p>The principles of the Treaty of Waitangi are incorporated into day-to-day practice. There is a specific current Māori health plan and all values and beliefs that the resident holds are acknowledged with the support of the Te Whare Tapa Whā model with support from cultural advisers within the local community available as required. Māori links are established through the DHB, Te Puke Marae and several community groups including Te Oro arts weaving group, Māori pastors and kaumātua.</p> <p>Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process and review. Discussions with staff confirmed that they are aware of the need to respond to</p>

		cultural differences. One resident interviewed confirmed their beliefs, values and practice are respected. Activities and displays in recognition of Māori values were visible in the facility on the days of the audit.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>There is a policy that describes spiritual care. Monthly church services, including Chinese Presbyterian and interdenominational services and weekly communion are conducted in the facility. Transport is available for residents of Hindu faith to attend the local temple. Residents interviewed confirmed that their spiritual needs were being met. The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. The activities planner include various cultural activities and interview with staff confirm there is a general understanding on how to care for residents coming from different cultural and ethnic backgrounds. The facility is continuing to maintain current community links and initiate new links where possible</p> <p>Information gathered during assessment including each resident's cultural beliefs and values, are used to help to develop a plan of care. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct that staff sign as part of the employment process. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, code of conduct and professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>The service has policies to guide practice that aligns with the Health and Disability Services Standards, for residents with aged care and</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>residential disability needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care.</p> <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, physiotherapist, hospice/palliative care team, district nurse, wound care specialist, mental health services for older persons, speech and language therapist and education of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The service utilises an online education platform to upskill staff knowledge.</p> <p>Other examples of good practice observed during the audit included the knocking on doors before entering a room, day to day discussions with residents and their families and staff interviewed being able to identify that they know the residents well.</p> <p>The quality programme includes a collation of several clinical indicator data to identify opportunities to improve care services to their residents. A comprehensive handover process promotes continuity of care delivery. The service utilises an electronic resident management system and supplementary documentation is readily available to access.</p> <p>CHT has a coordinated incident management system structure that ensures that resident and staff records (including vaccination status, NHI and working schedules) are updated daily for easy contact tracing as part of CHT Covid-19 preparedness plan.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. An open disclosure policy describes ways that information is provided to</p>

<p>provide an environment conducive to effective communication.</p>		<p>residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. Sixteen incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted in a timely manner after adverse events or at any time a resident deteriorates. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Focus group meetings (residents, relatives, and staff) are implemented whenever regular satisfaction survey results are below the target satisfaction rate.</p> <p>Access to interpreter services is available if needed, for residents who are unable to speak or understand English. Staff completed training in communicating effectively with residents with cognitive deficits and/or speech impediments (November 2021). Communication to families related to Covid-19 is published on the website, regular newsletters and individual emails are sent to relatives. Family members interviewed confirmed they are updated with any changes in health of their relative and feel informed about the facility's strategy under the Covid-19 preparedness framework.</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 Lansdowne is owned and operated by the CHT Healthcare Trust. The service provides hospital and rest home level care for up to 95 residents. On the day of the audit, there were 87 residents. This included 26 rest home level residents and 61 hospital level residents. There were two residents (hospital level care) on the young person with a disability (YPD) contract, and three (two hospital and one rest home level) under the long-term service chronic health care (LTS-CHC) contract, and one on an Interim contract (ACC). Forty rooms are</p>

		<p>certified as dual purpose. There was one room temporarily decommissioned due to internal renovations within the room. There are no double rooms.</p> <p>The organisation has a philosophy of care, which includes a vision and mission statement. The business plan for April 2021-March 2022 is being implemented and progress is reviewed quarterly. Each facility sets their own goals to align with the CHT business plan. CHT Lansdowne set seven goals for the period and focus on embedding the electronic clinical documentation system, falls prevention, managing complex wounds, meaningful activities, improve customer satisfaction, staff wellbeing. The current plan main focus for all areas is on Covid-19 business preparedness and the associated risks but also on the current workforce issues.</p> <p>The previous 2019/2020 business plan was reviewed and signed off. The area manager confirmed the strategic plan for 2022/2023 was developed in December 2021 and will be published in March 2022. A business continuity plan and Covid preparedness framework is integrated in all levels of the business plan.</p> <p>The unit manager is a registered nurse and been in the role since 2015 and have extensive experience in clinical management, management of staff and aged care. She maintains an annual practicing certificate and regularly attended CHT management training. The clinical coordinator is a registered nurse and been in the role since 2016.</p> <p>The unit manager reports weekly to the area manager on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past 12 months including a hazard management, governance and delegation and performance management and discipline.</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>In the absence of the unit manager, the area manager is in charge with support from the clinical coordinator, care staff and head office.</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 advised that she is responsible for providing 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 policies are communicated to staff in the staff meetings.</p> <p>A range of data (e.g. falls, incidents, property incidents, complaints, staff incidents, complaints, restraint, and medication errors) are collected, collated, and analysed at head office. Managers interviewed (area manager, unit manager and clinical coordinator) advised these results are shared with staff. An internal audit programme consists of two six-monthly audits completed by the area manager (March and October 2021) and include all aspects of the Code of Rights, human resource practices, restraint, and infection control. The area manager completes six monthly audits. There was evidence in the staff meetings to verify staff were informed of the internal audit results. Other audits include monthly health and safety internal audits, medication management (including Medimap), pandemic preparedness, wound and restraint audits that is completed by designated staff in the facility.</p> <p>Resident satisfaction surveys are regularly sent to residents and family, scores are collated, and post interviews are conducted by the area manager. Focus groups (staff, resident and relatives involved) are utilised to ensure a robust corrective action plan is developed and implemented for areas that require improvement.</p> <p>Corrective actions were identified and signed off in a timely manner. Issues identified during monthly meetings (combined quality/health and safety, staff, and resident meetings) and from complaints were addressed, followed up or signed off.</p> <p>The 2020/2021/2022 meeting minutes were reviewed and include</p>
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		<p>discussions around Covid-19 preparedness strategies. Interviews with staff confirmed that meeting minutes are posted for them to read/review. Resident/family meetings take place quarterly.</p> <p>A health and safety programme is in place that meets current legislative requirements. A healthcare assistant and RN are the designated health and safety officers and have completed formal training in hazard identification and WorkSafe management. An interview with both the health and safety officers and review of health and safety documentation confirmed that legislative requirements are being upheld. Internal audits related to the environment and equipment are completed monthly. The health and safety committee meets quarterly. External contractors and all new staff have been orientated to the facility's health and safety programme including Covid-19 preparedness requirements. The hazard register was up to date and is reviewed monthly. Health and safety goals specific to the facility are reviewed quarterly by the health and safety committee. A hazardous substance register is in place. There were safety signs visible where renovations took place within one room.</p> <p>Staff have completed manual handling and transfer education and competencies. The health and safety officer confirmed there was one recorded staff injury in the last 12 months related to manual handling and transfer.</p> <p>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. The physiotherapist interviewed confirmed transfer plans for residents are followed by staff and appropriate equipment is available. Sensor (buzzer) mats are used for those residents who are at risk of falling. These residents are checked frequently and are encouraged to be out of their rooms during the day so that they can be monitored more closely. Individual falls prevention strategies are implemented for residents that fall.</p> <p>The facility is allocated a continuous improvement rating for their fall's prevention strategies.</p>
Standard 1.2.4: Adverse Event Reporting	FA	There is an accidents and incidents reporting policy that is being

<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>		<p>implemented by the service.</p> <p>Sixteen accident/incident forms were randomly selected for review. A registered nurse conducts clinical follow-up of each adverse event. Neurological observations are conducted for unwitnessed falls and completed within the requirements of the policy. All adverse events reviewed demonstrated that appropriate clinical follow-up, open disclosure, and investigation took place. Adverse events are also reviewed and signed off by the unit manager. Relatives interviewed confirmed they are informed of any incidents.</p> <p>Trends are identified at head office with data benchmarked against the other sixteen CHT facilities. This benchmarked data is available electronically and also posted as a power point presentation at the monthly staff meetings and quality meetings. The area manager reports monthly all key quality performance data to the Board.</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 (e.g. police investigations, RN cover, pressure injuries). There were five section 31s reported to HealthCERT since the last audit (including one police investigation, one for RN unavailability, two for missing residents, one sudden death referred to the coronial service).</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>	<p>FA</p>	<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. Eight staff files (one clinical coordinator/RN, three staff RNs, three 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 well orientated to the service. Evidence of an orientation programme being completed was sighted in the staff files. Orientation</p>

		<p>includes an Altura learning package and introduction to the Code of Rights, health and safety including emergency preparedness, incident reporting, ageing process, restraint minimisation, communication, and infection control.</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. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Seven of the eight (excluding clinical coordinator) registered nurses employed have completed interRAI training, all have maintained their competency.</p> <p>The unit manager attended monthly CHT managers' meetings and attended professional development relating to managing an aged care service. The clinical coordinator has maintained training records that reflect attendance at the following in-services in 2021: foundations of spiritual care, RN clinical study day and palliative option initiative (three-day series).</p> <p>There are 44 HCAs with 35 completed level four and four completed level 3 National certificate in Health and Wellbeing. The area manager confirmed several HCAs are enrolled at different levels with Careerforce to further their qualification. There are two staff qualified as Careerforce assessors.</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 policy includes staff rationale and skill mix.</p> <p>There were 87 residents at the facility at the time of the audit.</p> <p>Sufficient staff are rostered on to manage the care requirements of the residents. The area manager confirmed that the workforce of HCA are stable, and a full complement of RNs are rostered. The roster reviewed confirmed all shifts are covered. Agency staff are used when casual staff or own staff are not available. There is a clearly documented process to manage risk in case of RN unavailability and include RNs to extend shifts and work 12-hour days or the shifts will be covered by the unit manager and clinical coordinator when all other options fail. All</p>

	<p>current registered nurse roles are filled with no vacancies.</p> <p>There is allowance/contingency in the roster to increase staff hours with 30 hours per day as part of the pandemic planning strategy.</p> <p>The unit manager and clinical coordinator support the RNs Monday – Friday.</p> <p>Sheffield - 20 beds (19 hospital level residents). RN 7 am-3.30 pm with 2 HCAs 7 am-3 pm and 2 HCAs 7 am-1.30 pm. RN 3 pm-11.30 pm with 2 HCAs 3 pm-11 pm.</p> <p>Botany - 20 beds (18 hospital level care residents). AM: RN 7 am-3.30 pm with 2 HCAs 7 am-3 pm and 2 HCAs 7 am-1.30 pm. PM: RN 3 pm-9.30 pm with 2 HCAs 3 pm-11 pm.</p> <p>Cascade - 15 beds (15 hospital level residents). AM: RN 7 am-3.30 pm also oversees Wallace and Picton after 1.30 pm with 2 HCAs 7 am-3 pm and one HCA 7 am-1.30 pm. PM: RN from Sheffield and Botany oversees Cascade on pm shift with one HCA 3 pm-11 pm and one from 3 pm-8 pm.</p> <p>Also, one floater HCA for Cascade/Sheffield and Botany 3 pm-8 pm.</p> <p>Wallace/Picton - 40 beds (9 Hospital and 26 Rest home level residents). AM: RN 7 am-3.30 pm with 3 HCAs 7 am-3 pm and one 7 am-1.30 pm. PM: RN 3 pm-11.30 pm and 2HCAs 3 pm-11 pm and one from 3 pm-8 pm.</p> <p>NIGHT RN 11 pm -7 am and 4 HCAs (one for Wallace/Picton, one for Sheffield, one for Botany and one for Cascade).</p> <p>Activities: Monday- Sundays 70 hours per week.</p> <p>There is one medication competent staff member on each shift to support the RN (included in above numbers).</p>
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		<p>An external contractor employs the laundry and cleaning staff.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</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 electronic record supplemented by a resident file. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public are not able to view sensitive resident information. Entries in records are legible, dated and electronically signed by the relevant HCA or RN. Documents are archived on site in an appropriate secure room. Staff have access to the electronic file with an individual username and passcode. The business continuity plan includes risk mitigation in case of an IT failure.</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 services has been identified.</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, potential residents, and their families. Resident agreements contain all detail required under the aged residential care contract. The ten admission agreements reviewed meet the requirements of the ARRC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information</p>

		prior to and on entry to the service. Family members reported that the unit manager or clinical coordinator are available to answer any questions regarding the admission process.
<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 was transferred to hospital acutely with vomiting/dehydration on the day of audit. All appropriate documentation and communication were completed. Transfer to the hospital and all appropriate actions were documented in the progress notes. The required documentation was provided to ambulance staff in the DHB 'yellow envelope' described above.</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 were no residents self-medicating on the day of audit, there are no standing orders in use and 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. Registered nurses 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 temperatures for the medication fridges and two medication rooms are checked daily and were within safe limits. Eye drops and topical medications were dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twenty medication charts were reviewed. Medications are reviewed at least</p>

		three-monthly by the GP/NP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted and effectiveness post-administration documented.
<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>Food services are outsourced to an external contractor. The chef unit manager oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring September 2022. All kitchen staff have food safety and hand hygiene training. The kitchen is adjacent to the rest home (Wallace) dining room and meals are served from the bain-marie in the kitchen to residents in the dining room for Wallace and Picton wings by the kitchen staff. Meals are plated in the kitchen for the Sheffield, Cascade and Botany dining areas and delivered in a scan box to be served by the HCAs. There is specialised crockery and cutlery for use as required. On the days 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. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements, 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, including requirements for those residents on the REAP (replenish and energy protein) programme. The four-weekly seasonal menu cycle is written and approved by an external dietitian. Audits are implemented to monitor performance and residents/families interviewed commented positively regarding the standard and quantity of food.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate</p>	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons

<p>risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>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>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<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 age-related residential care (ARRC) and LTS-CHC residents' files reviewed. Initial interRAI assessments and reviews are evident for all resident files sampled apart from the YPD file which did not require an interRAI assessment and the short-term ACC client.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning 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 were resident centred. Interventions documented support needs and provided 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 dietitian, physiotherapist, podiatrist, wound care specialist and community mental health team. The HCAs 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 Consumers receive adequate and appropriate services in order</p>	<p>FA</p>	<p>When a resident's condition changes, the RN will initiate a GP/NP consultation. Staff stated that they notify family members about any</p>

<p>to meet their assessed needs and desired outcomes.</p>		<p>changes in their relative's health status. Care plans have been updated as residents' needs changed. The nurse 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. Specialist continence advice and wound care is available as needed and this could be described</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included four chronic wounds, eight skin tears, one surgical wound and one stage 2 pressure injury (community acquired). The service had sufficient pressure injury prevention equipment available, including air mattresses and pressure relieving cushions. These were sighted on the day of audit.</p> <p>Monitoring forms are in use as applicable, such as weight, repositioning, 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 three activity coordinators (two undertaking diversional therapy qualifications) all with current first aid certificates covering seven days between them who plan and lead all activities. Residents were observed participating in planned group and one on one activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. A printed copy is delivered to each resident's room and emailed to family weekly. 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, gardening group, pet therapy, and bingo. The residents enjoy happy hour twice per month.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are weekly outings, and the service utilises a contracted wheelchair accessible minibus. There are regular entertainers visiting</p>

		<p>the facility when Covid restrictions permit. Special events like Mat ariki, birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as cultural dance groups, churches, and children's groups (again, subject to Covid level restrictions). A Chinese church visits monthly and Hindu residents have trips to the local temple.</p> <p>The younger residents (YPD and LTS-CHC) have individualised activity plans that take account of their age, culture, and abilities. They are encouraged to maintain links with the local community and are supported with the use of their own phones, laptops, and tablets to have regular contact with friends and family. Activities observed include age-appropriate use of technology and one-on-one discussion sessions.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, which 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. Resident meetings are held bi-monthly. Residents interviewed commented positively about the activity programme, especially the cultural connections and associated activities. Satisfaction surveys show activities ratings are sitting at 76%, an improvement from previous years (60%).</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>Six of the ten resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status (four had not been in the service for six months), which included progression towards written goals. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical</p>

<p>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>		<p>and non-medical services. Referral documentation is maintained on resident files. The unit coordinator, clinical coordinator and registered nurses interviewed could give examples of where a resident was admitted with chronic ulcers and wound nurse specialist input had been sought. Discussion with the clinical coordinator and registered nurses identified that the service has access to a wide range of support either through the GP, NP, specialists, and allied health services as required.</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 service delivery.</p>	<p>FA</p>	<p>Cleaning services are outsourced to an external provider and there are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and there is no decanting of chemicals. Safety datasheets for chemicals are readily accessible for staff. All chemicals were stored in locked areas throughout the facility.</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 consists of five wings on one level. The building has a current building warrant of fitness that expires 4 March 2022. The full-time maintenance person oversees three CHT sites and is on site at Lansdowne one day a week and available at other times as required. A maintenance communication log is maintained and demonstrated that maintenance and repairs are addressed within a timely manner. There is a planned maintenance schedule in place. The maintenance person is a qualified electrical tester and completes the test and tag of all electrical equipment. Hot water temperature checks in resident areas are completed monthly and are below 45 degrees Celsius. Essential contractors are available 24 hours.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. External areas are well maintained around the existing building, and include internal courtyards with flower and vegetable beds, some of which are raised for wheelchair accessibility. Seating and shade are available. Staff stated they had sufficient equipment to safely deliver the cares as outlined in</p>

		the resident care plans.
<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>	FA	<p>There are a mix of rooms with shared ensuites (Sheffield, Botany and Cascade wings) and there is access to communal facilities for residents in rooms without ensuites. All rooms have hand basins. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms, communal showers, and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Shared ensuite and communal toilet/shower facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment. Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents.</p>
<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. Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer. They are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas for residents who prefer quieter activities or visitors may sit. Cascade, Botany and Sheffield wings each have a combined lounge and dining area while Picton and Wallace wings share the main separate lounge and dining room. The lounge and dining areas are spacious, inviting, and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</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>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All laundry and personal items are outsourced. There are two defined areas – a ‘dirty’ area for linen/clothing awaiting collection and a ‘clean’ area for deliveries. Laundry is collected and delivered seven days a week. There were adequate supplies of linen sighted in cupboards.</p> <p>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.</p> <p>Sluice rooms were kept locked when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Cleaners are available seven days per week. Cleaning staff could adequately describe their responsibilities and procedures related to infection prevention and control.</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>A fire evacuation plan and emergency management plan are in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment, including fire equipment. Fire evacuation and drill completed on 5 October 2021 and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and gas cooking. The site has 5000 litres of emergency water in tanks in addition to bottled water within the building. Short-term back-up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents’ rooms and these were observed to be operational and within close proximity. The facility is secure at night and there is security lighting.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has heating that is thermostatically controlled. Staff and residents interviewed, stated that this is effective. All bedrooms and communal areas have at least one external window. There is one monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>CHT Lansdowne has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator (with a job description) with support from the unit manager, the clinical coordinator and staff involved in the infection control meetings that is linked to clinical, staff and quality meetings. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p> <p>There is appropriate isolation practices in place to minimise risk in case of a pandemic. Requirements and staff responsibilities under the Covid-19 response framework is discussed at staff meetings. Staff performed two simulations/scenario-based drills in December 2021.</p> <p>Infection control meetings are linked to the staff and combined quality and health and safety meetings.</p> <p>Resident education occurs during cares or opportunities at resident meetings. Visitors are reminded not to visit if they are feeling unwell.</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>	FA	<p>A registered nurse at CHT Lansdowne is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has good external support from the local laboratory, infection control team and IC nurse specialist at the DHB and</p>

		<p>CHT head office. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available in all areas and at the main entrance.</p> <p>Staff were observed to practice good handwashing techniques. There is sufficient pandemic stock available including rapid antigen tests, isolation kits, masks, and other personal protective equipment (PPE). There is a clear framework and plan for cohorting of staff and residents. The facility is divided in two zones and staff do not work across zones.</p> <p>PPE stock is replenished through the MOH portal and coordinated by CHT head office. Isolation kits are readily available.</p> <p>Staff interviewed confirmed they adhere to cleaning practices for equipment use between resident's reusable items but also touch screens and computer equipment. All staff and residents (consented) received Covid-19 vaccinations and boosters. There is flowing soap and single use hand towels available in resident rooms, toilets, and communal bathrooms.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are CHT infection control policies and procedures appropriate for the size and complexity of the service. Policies are available electronically on file or in hard copy. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies have been reviewed and updated. Policies include information and a response framework on Covid-19 preparedness including cleaning and laundry practices. The cleaner interviewed confirmed during interview a knowledge of cleaning requirements and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak</p>

		<p>has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p> <p>Staff completed competencies for handwashing and the correct use of PPE. Scheduled training related to the facility's Covid-19 preparedness occur and during different alert levels of Covid-19, meetings increased to twice a day.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection 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 signs and symptoms of infection. Antimicrobial use and duration for each resident is recorded as part of the data collation. The GP/NP reviews the monthly infection data. Short-term care plans are used. Surveillance of all infections is entered into an electronic resident system and extracts provide a monthly infection summary. This data is monitored, evaluated, and reported monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager.</p> <p>There has been one respiratory outbreak in August 2021, appropriately managed with the relevant notification and of short duration. Debrief notes (reviewed) recorded lessons learned related to isolation practices.</p> <p>A facility Covid-19 preparedness framework is implemented at all levels of service delivery. All visitors to the facility are required to sign in electronically, book online appointment time, wear a mask, show a vaccine passport on entry, complete a health declaration with temperature checking and Covid QR scanning. There are special arrangements in place for children and unvaccinated visitors. Residents going out in the community have to isolate for 72 hours depending on a risk assessment outcome or a rapid antigen screening test will be done.</p> <p>Covid screening is done prior to entry to the facility for all new residents.</p>
Standard 2.1.1: Restraint minimisation	FA	The service has documented systems in place to ensure the use of

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>restraint is actively minimised. There were two residents with restraint (one bedrail and one with bedrail and lap belt) and three residents with an enabler (lap belts and/or bedrails). Enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Staff interviews and staff records evidenced that guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers and managing of challenging behaviour has been provided. Restraint has been discussed as part of quality/health and safety meetings. The area manager completes six monthly restraint audits.</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 designated restraint coordinator. Assessment and approval processes for restraint use include the restraint coordinator, registered nurses, resident and/or EPOA/family and medical practitioner.</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>The service completes a comprehensive assessment for each resident who requires restraint or enabler interventions that meets criteria (a) – (h). Assessments are undertaken by either the restraint coordinator or a registered nurse in partnership with the family/whānau and medical practitioner as evidenced in all resident files where a restraint or enabler was being used. In all files reviewed, consents for the use of the restraint/enabler were also completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation policy and register identify those restraints are put in place only where it is clinically indicated and justified, and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk.</p>

		<p>Monitoring forms document regular monitoring at the frequency determined by the risk level, low risk 4-hourly to high risk 2-hourly.</p> <p>The service has a restraint and enablers register, which is updated each month. Restraint use is audited in the six-monthly internal audit. The completion of restraint forms (e.g. assessments, monitoring forms, six-monthly reviews) are monitored a minimum of monthly by the restraint coordinator.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service evaluates the use of each restraint or an enabler every six months. In the five files reviewed (two restraints and three enablers), evaluations had been completed with the resident, family/whānau and restraint coordinator.</p> <p>Restraint practices are reviewed every month by the restraint coordinator with data shared at the staff/quality and RN meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The service actively reviews restraint as part of the internal audit programme and reporting cycle. The restraint minimisation programme is reviewed annually at head office with input provided by each CHT facility including Lansdowne. Review processes include policy and procedures review, trends analysis around restraint use and the review of staff education programmes.</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 audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The clinical coordinator reviews all incidents and accidents on a regular basis and reports trends to a variety of meetings. Data collected and collated are used to identify areas that require improvement. The incidence of falls is reviewed at the quality meetings and the clinical meeting. The meetings noted that the falls rate per 1000 bed nights are still higher than the benchmarking target of 10.6/1000 bed nights for CHT between January and April 2021. A plan was implemented to address the high incidence of falls but focus on the identified group of residents.</p>	<p>A process was put in place to reduce falls and improve resident safety. ‘Events per client’ data is collated monthly. Twelve individuals were identified as having recurrent falls. There were 77 falls events recorded for January 2021-April 2021 for the group of individuals. A moving and handling committee was formed to focus on the decrease of falls within the facility and identified group of residents. The individual falls plans, as well as a falls overviews became a fixed agenda item at the health and safety meetings, quality, and staff meetings.</p> <p>Residents’ falls are monitored monthly with strategies implemented to reduce the number of falls including:</p> <p>a) Highlighting residents at risk and implement individualised interventions to including improving mobility through exercises, timely GP assessment for underlying causes and ensure optimisation of medication, physiotherapy assessments and</p>

			<p>development of mobility plans, ensure optimal nutrition and hydration through REAP, high protein smoothies to build muscle mass and include a multidisciplinary participation including the resident/whānau.</p> <p>b) Review of the resident's environment including implementation of falls prevention equipment such as sensor mats and landing mats. Weekly call bell reports highlights call bell response time and creates awareness and discussions for improvement. Rosters are reviewed to ensure sufficient staff numbers for oversight.</p> <p>c) Increase monitoring through individual scheduled toilet regimens, supervision, and intentional rounding.</p> <p>Healthcare assistants and RNs interviewed were knowledgeable regarding preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly. A review of the data evidenced a decrease of falls incidents for the specific group of residents by 35% in May 2021-August 2021 and 48% by November 2021 and a 20% decrease facility wide from Q1-Q4.</p> <p>A new group of residents were identified in November 2021 with the same strategies put in place. The data evidenced positive outcomes for the resident group.</p>
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End of the report.