

# CHT Healthcare Trust - Peacehaven Resthome & Hospital

---

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, 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>	Peacehaven Resthome & 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: 18 April 2017    End date: 19 April 2017
<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>	32

# 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
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

Peacehaven is owned and operated by the CHT Healthcare Trust and provides hospital (medical and geriatric) and rest home level care for up to 60 residents. Fifteen of the sixty resident rooms were not yet occupied following refurbishment/rebuild. These rooms were verified in a partial provisional audit completed February 2017. Completion of the CPU was held up.

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 and management.

On the day of the audit, there were 32 residents. A unit manager, who is a registered nurse and is well qualified and experienced for the role, oversees the service and is supported by the area manager and clinical coordinator. Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit identified an area for improvement around care plan interventions and completing the new extension.

The service has received a continual improvement rating relating to good practice.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Staff at Peacehaven strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to. There are sufficient staff and appropriate staff coverage for the effective delivery of care and support.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents one to three monthly.

The activities team 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.

Medications are managed appropriately in line with accepted guidelines. The registered nurses administer medications and have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Peacehaven has been undergoing a refurbishment and remodelling programme to increase its beds from 45 to 60. This building programme has added an additional level to the building, which includes nine additional dual-purpose beds and a multipurpose kitchen/dining/lounge area. An additional six dual-purpose beds have been added to level two (ground floor), which will result in thirty-seven beds on this level. The service is waiting for CPU sign-off before these rooms can be occupied.

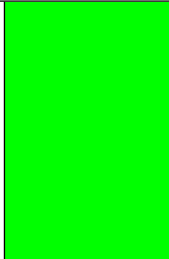
The current building has a current warrant of fitness and an updated emergency evacuation plan. There is a reactive and planned maintenance programme in place. Chemicals are stored safely throughout the facility. All except one resident room is single occupancy and the majority have access to en-suites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaners and maintenance staff are providing appropriate services. Laundry is out-sourced. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Peacehaven Hospital and Rest Home has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were five hospital residents with restraint and no residents with an enabler. Restraint management processes are adhered to.

## Infection prevention and control

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

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 the service providers. Documentation evidences 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. 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.

## 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>	1	47	0	2	0	0	0
<b>Criteria</b>	1	97	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 staff (four healthcare assistants, four registered nurses (RN), one activities coordinator, one area manager and one unit manager) confirm their familiarity with the Code. Interviews with five residents (three rest home and two hospital) and four families (of hospital residents) confirmed the services being provided are in line with the Code.</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 choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files reviewed (four hospital and two rest home level of care) demonstrated that advanced directives are signed for separately. There was evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Four healthcare assistants (HCAs) and four registered nurses (RNs) interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All six resident files reviewed had a signed admission agreement.</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>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friend's networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. A complaints form is freely available for residents and relatives. Information about complaints is provided on admission. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a computerised complaints register. Verbal and written complaints are documented. Ten complaint forms were reviewed from May 2016 to April 2017. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants and discussed in meetings, as relevant. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the staff discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code of Rights.</p>
<p>Standard 1.1.3: Independence,</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information</p>

<p>Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>A policy describes spiritual care. Church services are conducted weekly for different denominations. All residents interviewed indicated that their spiritual needs are being met when required.</p> <p>There is a policy on abuse and neglect and staff have received training.</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 established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. No residents identified as Māori on the day of the audit.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review, as demonstrated in resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness. The service currently has some Chinese residents, for which staff and family are able to provide interpreter services.</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 which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p>	CI	<p>The service has policies to guide practice that aligns with the Health and Disability Services Standards for residents with aged care and residential disability needs. Staffing policies include pre-</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>employment and the requirement to attend orientation and ongoing in-service training. The monthly and annual resident satisfaction surveys reflected high levels of satisfaction with the services provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. The service has been awarded a continuous improvement rating for excellence in providing holistic care in the last days of life and for the use of herbs remedies and treatment of chronic wounds.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure, alerts staff of their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Thirteen incidents/accidents forms were reviewed which included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>CHT Peacehaven is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital (medical and geriatric) level care for up to 60 residents. The service is awaiting final sign off to open a further 15 beds from a partial provisional audit completed on 8 February 2017. These rooms were not in use. On the day of the audit, there were 32 residents, 4 rest home level and 28 hospital level residents. All resident rooms are dual-purpose rooms. Peacehaven is part of the CHT Auckland region and led by an area manager who is a practising registered nurse.</p> <p>The unit manager is a registered nurse and maintains an annual practising certificate. She has been in a management role at the facility since October 2016 having previously been the clinical coordinator for three years. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Peacehaven has a unit business plan in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past twelve months.</p>
<p>Standard 1.2.2: Service</p>	<p>FA</p>	<p>In the absence of the unit manager, the clinical coordinator is in charge with support from the senior</p>

<p>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>management team and the area manager.</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>There is an organisational business/strategic plan that includes quality goals and risk management plans for Peacehaven. Interviews with staff confirmed that quality data is discussed at monthly staff/quality/health and safety meetings to which all staff are invited. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance.</p> <p>The service's policies are reviewed at national level, with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to policy manuals.</p> <p>Resident/relative meetings are held monthly and a quarterly newsletter is sent to all family and residents.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</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>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The unit manager along with the health and safety team investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff/quality meetings as well as RN meetings, including actions to minimise recurrence. A registered nurse conducts clinical follow up of residents. Ten incident forms sampled demonstrated that appropriate clinical follow up and investigation occurred following incidents (link 1.3.6.1).</p> <p>Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications since the previous audit.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one clinical coordinator, two registered nurses, an activities coordinator and two healthcare assistants) and evidence that reference checks were completed before employment was provided.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Seven of the eight registered nurses have completed interRAI training and one is in progress. Annual staff appraisals were evident in all staff files reviewed.</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. Sufficient staff are rostered on to manage the care requirements of the residents. At least two registered nurses are on at any one time for morning and one on the afternoon shift and one at night across the two floors. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. There are draft rosters available with the increase of resident numbers when the extra rooms are opened.</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.</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</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The unit manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to</p>

<p>their need for services has been identified.</p>		<p>admission and had the opportunity to discuss the admission agreement with the unit manager and clinical coordinator.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require admission to hospital are managed appropriately and relevant information is communicated to the DHB. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely. The service use an electronic medications system. Weekly medication audits evidence medication administration practice complies with the medication chart. Registered nurses and senior healthcare assistants complete an annual medication competency and medication education. Robotic medication rolls are checked on delivery by the RN on duty. All imprest stock and 'as required' mediations are checked regularly for expiry dates. Eyedrops are dated on opening. There are no standing orders. There were no residents self-medicating on the day of audit. The medication fridge temperature is monitored daily.</p> <p>Twelve medication charts on the electronic medication system were reviewed. All charts met prescribing requirements including the indication for use of 'as required' medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals and baking is done on-site by a contracted service. The Monday to Friday qualified cook is supported by a weekend cook and kitchen assistants. The four-weekly seasonal menu has been reviewed by a dietitian. The cook receives resident dietary profiles for all residents and notified of any changes such as weight loss. Resident dislikes are known and accommodated. Modified diets including pureed/mince moist, diabetic and fortified foods are provided. Meals are plated, covered and transported in scan boxes to the downstairs dining room. Meals are served from the bain marie to residents in the dining room adjacent to the main kitchen. The cook was able to describe the Replenish Energy and Protein (REAP) programme and the fortified foods offered for each level. The four resident files reviewed of residents (three hospital and one rest home) on REAP level three and one REAP level two have gained weight with no further weight loss.</p> <p>The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and end cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents interviewed were satisfied with the</p>

		quality and variety of food served.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Resident files reviewed indicated that all appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Files reviewed contained appropriate completed assessment tools and assessments that were reviewed at least six-monthly or, when there was a change to a resident's health condition. The interRAI assessments have been completed for all residents and care plans reviewed were developed based on these assessments. Additional assessments for management of behaviour and wound care were appropriately completed according to need.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Long-term care plans reviewed described the support required to meet the resident's needs and goals and identified allied health involvement. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. There was documented input into care plans from the resident/relative and care professionals including the podiatrist, physiotherapist, specialist wound care nurse, gerontology nurse and the mental health team.
<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>	PA Low	<p>Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound care nurse specialist). If external medical advice is required, this will be actioned by the GP.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care.</p>



		<p>Specialist continence advice is available through the DHB.</p> <p>Wound assessment, monitoring and wound management plans are in place for fifteen wounds including three facility acquired pressure injuries (two stage II and one unstageable). Not all wounds had been evaluated at the documented frequency. The RNs have access to specialist nursing wound care management advice through the DHB and the district nurses.</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>An activities coordinator is a qualified HCA who employed to coordinate and implement the activities programme for rest home and hospital residents. There is a Monday to Friday programme from 9.30am to 3.30pm with organised activities in the weekends such as church services, movies and walks with the healthcare assistants. Volunteers are involving in weekend activities including one-on-one with residents. Group activities reflect ordinary patterns of life and include planned visits to the community, inter-home visits, concerts and other activities. A wheelchair access bus is hired for outings. Community visitors include entertainers, school children, youth groups, students and animal therapy visits. Each resident is free to choose whether they wish to participate in the group activities programme. There is allocated one-on-one time for residents who choose not to or unable to participate in group activities.</p> <p>A lifestyle questionnaire is completed soon after a resident's admission. An individual activities plan is developed for each resident and reviewed six-monthly in consultation with the resident and RN. Participation is monitored. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. The long-term care plans were evaluated at least six-monthly or earlier for health changes in all files reviewed. There is at least a three-monthly review by the GP. Written evaluations record the resident's progress against the resident goals. Short-term care plans reviewed were evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files reviewed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Evidence of referrals were sighted on the files reviewed.</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>There was evidence of re-assessment for a resident to higher level of care.</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>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 stored safely throughout the facility. There is no decanting of chemicals. Safety data sheets are readily available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 1 June 2017, however a certificate for public use has not yet been obtained for the fifteen bed extension across level two and three. This area remains closed off to staff and residents.</p> <p>The building consists of three floors. Level one (basement) remains unchanged with twelve bedrooms (including two double rooms). Level two (ground floor) contains the original rest home and hospital area, plus an addition of six new bedrooms (not yet opened). This is the main floor of the rest home and hospital. There has been remodelling and refurbishment of all level two and several rooms are in the process of being fully refurbished. Level three contains a new lounge/dining/kitchenette area, a nurse's station, a sluice room, a lockable storage area and nine single bedrooms (this floor is not yet opened). All nine bedrooms have ensuite toilets, hand basins and showers with two single bedrooms sharing an ensuite.</p> <p>There are two lifts (one between level one and level two [ground floor] and the other between the level two and level three). Stairs are available. There is disabled access from the car park to level one. Access from the car park to level two is ultimately by stairs and disability access ramp.</p> <p>The full-time maintenance person oversees four CHT sites and is on-site at Peacehaven one day a week and available at other times as required. A maintenance communication log is maintained and demonstrates 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 of ensuites 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, however, the external landscaping for the new extension has not been completed. This area</p>

		remains fenced off to residents. Seating and shade is available. Staff stated they had sufficient equipment to safely deliver the cares as outlined in 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	There are a mix of rooms with ensuites and there is access to communal facilities for resident in rooms without ensuites. Fixtures, fittings and flooring in all areas (including the new extension- link 1.4.2.1) are appropriate and toilets/showers are constructed for ease of cleaning. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident rooms are of an appropriate size to allow care to be provided for rest home or hospital level of care. Residents can safely move about the room with the use of mobility aids and there is sufficient space for the use of hoists, for the safe transfer of residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Resident rooms have been completed in the 15-bed extension, however a CPU has not yet been obtained (link 1.4.2.1).
<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	The communal areas include a lounge and dining area on each level. These are large enough to cater for activities (as observed taking place). Seating and space can be arranged to allow both individual and group activities to occur. There are sufficient communal areas for residents who prefer quieter activities or for visitors.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The cleaners have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility. Cleaning trolleys are stored in a locked cupboard when not in use. Safety data sheets are available.</p> <p>All laundry is completed off-site and picked and delivered daily. Separate trolleys are used for the transport of clean and dirty linen though a downstairs entrance. There is a washing machine</p>

		available for delicate clothing if required.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan has been updated 5 April 2017 to include the 15-bed extension. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A fire drill has been completed. A contracted service provides checking of all facility equipment, including fire equipment. Fire training 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. 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.</p> <p>There are call bells in the residents' rooms and these were observed to be within close proximity. The call bells within the new unit are operational.</p> <p>There is security lighting at night and access to the building is by bell. There are random night security guard rounds.</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>There is central heating throughout the facility. Some residents who feel the cold also have oil heaters in their rooms. All rooms have external windows that open, allowing plenty of natural sunlight.</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>Peacehaven has an established infection control programme. The IC team who meet monthly leads the programme. Monthly reports from the IC team are integrated into the staff/quality/health and safety meetings. 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. The clinical manager who is a registered nurse is the designated infection control coordinator with support from all staff. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. 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.</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>	FA	<p>There are CHT infection control policies and procedures appropriate for the size and complexity of the service. 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. The policies have been reviewed and updated.</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>	FA	<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 attends the CHT infection control forum and provided with education and updates through this forum. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak 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>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the staff/quality/health and safety meetings. If there is an</p>

<p>that have been specified in the infection control programme.</p>		<p>emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the unit manager. The last outbreak was in May 2015 and was appropriately managed.</p> <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinators collate information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports are completed for all infections. Infections are analysed for trends and quality improvements. Graphs and relevant information is communicated to staff and documented in RN and staff/quality meetings.</p> <p>Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were six residents with restraint and no residents with an enabler. Four residents have bedrails as a restraint, one has a lap belt and one has table bedrails and a lap belt.</p> <p>All necessary documentation has been completed in relation to the restraints. 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. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings and monthly, as part of the restraint group. A registered nurse is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A registered nurse is the restraint coordinator. The assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner. The restraint team monitors and checks all restraints at least monthly.</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 comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau in the four restraint files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is only put in place 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. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed and appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every six months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month at registered nurse's meetings which include the facility restraint coordinator. 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>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six-monthly or sooner if a need is identified. The restraint coordinator and the other RN's complete reviews. Any adverse outcomes are reported at the monthly registered nurses and the staff/quality/health and safety 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)
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There was evidence of monitoring a resident's health status such as: two-hourly turning charts, food and fluid charts, regular monitoring of bowels, monthly weights, blood pressure, blood sugar levels, behaviour and pain monitoring. Wound assessments had been completed for fifteen wounds including three pressure injuries. Frequency of required wound evaluations were documented on the wound assessment form but not always documented as completed. Interventions had not been documented post incident for one resident.	(i)Wound evaluations for five of fifteen wounds had not been completed as per the documented frequency. (ii) There were no documented interventions to manage risk for one resident with two incidents of wandering and one fall.	(i)Ensure wounds are documented as evaluated at the documented frequency. (ii) Ensure interventions are documented to mitigate further risk for resident's post incidents.  90 days
Criterion 1.4.2.1 All buildings, plant, and equipment	PA Low	The building has a current building warrant of fitness that expires 1 June 2017. However, a certificate for public use has not yet been obtained for the 15 new bed extension across level two and three. Advised that the CPU has not been signed out as further building	The certificate for public use has not been obtained for the new extension. This finding remains open from	Ensure there is a certificate for public use in place prior to



comply with legislation.		requirements were needed to meet the CPU requirements. This process has slowed up the closing out of corrective actions. This area remains closed off to staff and residents. The rooms are still have been furnished and handrails are in place.	their partial provisional audit 7 February 2017.	occupancy.  Prior to occupancy days
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	External areas are well maintained around the existing building, however, the external landscaping for the new extension has not been completed. This area remains fenced off to residents. Advised this will be completed by September.	The external landscaping for the new extension has not yet been completed. This finding remains open from their partial provisional audit 7 February 2017.	Ensure landscaping is completed at the end of the building programme.  90 days

## 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>1)The service focuses on providing comfort, care and compassion for residents and families during the last days of life. There is a close liaison with GPs and the hospice team who support the care team and families to provide excellent holistic care with the upmost respect for the resident during the last days of life.</p> <p>2)The service</p>	<p>Since April 2015 the service has strived to achieve excellence in holistic care for residents during the last days of life. To achieve their goal the following has been implemented: a) good working relationship with GPs, hospice and chaplaincy services, b) last days of life resource nurse/RN at the facility (interviewed), c) ongoing palliative care education provided by hospice nurse specialists around the last days of life, d) identifying the residents dying wishes in consultation with the families and ensuring all of the team are informed including funeral directors, e) acknowledging staff feelings and offering debriefing sessions held by employee assistance counsellors, e) caring for the families ensuring they are being kept involved and informed on all aspects of care, f) allowing other residents and staff to pay their respects on the death of a resident by a photo and candle in the hallway and an on-site church service. Many staff attend the funerals and the unit manager has been asked on several occasions to present a eulogy at the resident’s funeral. The resource nurse and staff interviewed stated they are very well supported by the management, GPs and hospice. There are complimentary letters and cards from families that evidence excellence in care and compassion over their relative last days of life. From April 2015 to date, there have been 31 palliative care deaths and 22 letters/cards of appreciation with specific mention of excellent care and respect shown toward them and their</p>

		<p>researched the old folk remedies of the herbal properties of apple cider vinegar and tea used to heal wounds. The success of the project was reliant on the multidisciplinary team, the two residents involved and their families. The two chronic wounds have shown a marked improvement in healing and the simple yet effective wound care management has become part of wound care practice at Peacehaven.</p>	<p>past loved ones.</p> <p>2)In April 2016 the service had one resident with a chronic wound being treated with antibiotics and was odorous. The service researched (including laboratory studies) the use of apple cider vinegar and tea in the healing of wounds, prevention of infections and odour control and commenced the treatment. There was close monitoring (including wound evaluations, monthly reports and ongoing consultation with the GP, practice nurses, district nurse and hospice specialists). In October 2016, a second resident with a chronic wound was commenced on the wound management regime of apple cider vinegar cleansing and tea bags. Both wounds have improved with red granulating areas and no infections, reduced in size and have no odours. Photographs evidence the healing progress. There has been a positive impact on the two residents with the chronic wounds such as reduced number of dressings per week, no antibiotic use which has lessened the risk of multi-resistant organisms and has been effective in odour control, which has had a positive impact for family and visitors. The wound management regime has proven to be effective with alternative pharmaceutical preparations and specialised wound dressings.</p> <p>Both projects were presented to the organisational awards with the service receiving a merit award in both sections</p>
--	--	--	--

End of the report.