

CHT Healthcare Trust - CHT Glynavon

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:

Legal entity:	CHT Healthcare Trust	
Premises audited:	CHT Glynavon	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 13 January 2019	End date: 14 January 2019
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:	27	

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

Glynavon is part of the CHT group of facilities. The service provides care for up to 33 residents requiring two levels of care (hospital – geriatric/medical and rest home). On the day of audit there were 27 residents.

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

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

This audit identified the service continues to fully meet the HDSS standards.

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 that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The service 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 residents at times that meet their needs.

There is an established system for the management of complaints, which meets timeframes established by HDC.

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 embedded into practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Continuum of service delivery

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.

There is a comprehensive admission package available prior to, or on entry to the service. 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 (GP), and visiting allied health professionals.

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

The activities coordinator and staff 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 report satisfaction with the activities programme.

All meals are cooked on-site by contracted staff. 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.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All except two bedrooms are single occupancy and some have shared ensuites. 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. Cleaning contractors and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

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

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. There is a suite of infection control policies and guidelines to support practice. 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 infection control coordinator (RN) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice.

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 nine staff (four healthcare assistants, two registered nurses, one activities coordinator, one cleaner, one maintenance) and one site manager for food and cleaning (external contractor) confirmed their familiarity with the Code and its application to their job role and responsibilities. Interviews with seven residents (five hospital level including one resident on the young person with a disability (YPD) and two rest home level) and three families (hospital level) confirmed that the services being provided are in line with the Code. Aspects of the Code are discussed at resident and staff/quality meetings.</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>The service has in place a policy for informed consent and advance directives. Advanced directives and/or resuscitation status are signed for separately by the competent resident. Completed advance directive and resuscitation forms were evident on six resident files reviewed (four hospital and two rest home). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Copies of EPOA are kept on the residents file where required and activated where necessary.</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. Interviews 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 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. Residents who wish to can go on regular outings in the facility van.</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. Complaints forms are available at reception. Information about complaints is provided on admission in the services guide. Interviews with residents and relatives demonstrated their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that contains details for each lodged complaint. There were three complaints lodged in 2018 and all complaint documentation was reviewed. All three complaints had an investigation, timeframes determined by the HDC were met and corrective actions (when required) and resolutions were implemented. Results are fed back to complainants and to staff in the staff/quality meeting minutes. No complaints have been lodged for 2019 (year to date).</p> <p>Discussions with residents and relatives confirmed that issues are addressed, and they feel comfortable to bring up concerns with the unit manager.</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 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>

		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 with instructions to ask the manager if they would like to receive the Code pamphlet.
<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>The service has policies, which align with the requirements of the Privacy Act and Health Information 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>Eight residents' rooms have (four) shared toilets. Privacy locks in the past have created issues around residents not being able to enter their toilet because their locked door is not unlocked when no longer in use. There was one case whereby privacy was an issue and the resident concerned was moved to another room with his own toilet. There have been no other reported cases of privacy being breached. Interviews with the residents involved, HCAs and the unit manager reported that the current situation is being managed appropriately without affecting the privacy of residents and in the event that it became a concern, action would be taken.</p> <p>A policy describes spiritual care. Church services are conducted at the facility. All residents interviewed indicated that resident's spiritual needs are being met when required.</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. 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>The unit manager reported that Glynavon has the highest number of Māori residents compared with other CHT facilities. A Māori chaplain provides church services at the facility. In addition, on the second Sunday of the month residents (Māori and non-Māori) are invited to attend a church service at the Otamarakau marae on a monthly basis. Five residents identified as Māori on the day of the audit and cultural needs were addressed in care plans sampled. Two of the residents were interviewed and confirmed that their needs were being met by the organisation.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, 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>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>Information gathered during assessment including residents' 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 regular training on cultural awareness.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<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 Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards. Staffing policies cover pre-employment processes and the new employee's requirement to attend orientation and ongoing in-service training. The area manager is responsible for completing the six-monthly internal audit programme. Monthly staff meetings and quarterly residents' meetings are conducted. Recently, a resident focus group has been organised. This group meets monthly to address specific areas of concern identified by the residents.</p> <p>There is a regular in-service education and training programme for staff that includes a mix of online education and inhouse in-service training. Staff interviewed stated that they feel supported by the unit manager and that they work together well as a team.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. A GP visits the facility weekly. The service receives support from the local district health board (DHB). Physiotherapy services are available for 3.5 hours per week. They complete assessments on all new residents and if a resident has had a fall. A podiatrist visits every six to eight weeks.</p> <p>The service has links with the local community and encourages residents to remain independent. An example was provided of a resident (young person with a disability) who regularly accesses the community independently in his wheelchair. Community organisations that residents access include (but are not limited to) a day care programme (Kauri Centre), Te Puke Men's Shed, and two-monthly concerts at Mount Maunganui.</p> <p>Residents and relatives interviewed spoke positively about the care and support provided.</p>

<p>Standard 1.1.9: Communication</p> <p>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. There is an interpreter policy in place and contact details of interpreters are available. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incidents/accidents forms were reviewed, and all of the completed forms indicated family were informed about the event. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>CHT Glynavon has been owned and operated by CHT Healthcare Trust since 2015. The service provides rest home and hospital level care for up to 33 residents. On the day of the audit, there were 14 rest home level and 13 hospital level residents. This included one resident on a younger-person with disability contract (physical). The remaining residents were on the aged residential care contract. Five rooms are designated as rest home only and the remaining twenty-eight rooms are designated as dual purpose.</p> <p>CHT has a documented philosophy of care, mission statement and overall business/strategic plan. The unit manager's performance plan identifies business goals for the current year. These goals are regularly reviewed and signed off when achieved.</p> <p>The unit manager is a registered nurse who maintains an annual practicing certificate. She has been in a management role at this facility for the past 22 years and has worked at this facility for the past 24 years. The unit manager reports to an area manager on a regular basis (minimum of monthly). She has completed in excess of eight hours of professional development over the past twelve months relating to managing an aged care facility.</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 CHT senior management team, the senior registered nurse and care staff.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<p>The performance plan for the facility includes quality goals (strategic themes) with associated actions,</p>

<p>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>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 policy are communicated to staff, as evidenced in meeting minutes.</p> <p>Quality data collected is collated and analysed. Quality data is regularly communicated to staff via monthly staff meetings.</p> <p>The internal audit programme consists of two six-monthly audits completed by the area manager. Areas of non-compliance include corrective action plans. There was evidence in the staff meetings to verify staff are informed of audit results. In addition, a monthly cleaning audit has been conducted to address concerns expressed by the residents/families. Data is benchmarked against other CHT facilities and is trended on a monthly basis. Where improvements are identified, corrective actions plans are put into place. They are signed off when completed. If the corrective action is ongoing, it is re-audited in six months (or sooner depending on the risk rating).</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (unit coordinator) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review March 2017).</p> <p>Resident satisfaction surveys are completed annually with each resident asked to complete a survey during their birthday month. Survey results reflect residents are satisfied with the services they are receiving. Resident/relative meetings are held quarterly. A resident focus group is currently being held every month with the aim of addressing concerns that have been expressed by a few of the residents (e.g., quality of food and the cleanliness of the facility). Improvements in both areas have been identified during the audit.</p> <p>Strategies are in place to reduce the number of residents' falls. The RN completes a falls assessment and the Tinetti balance assessment for all residents who are at risk of falling. In addition, all new residents and residents who have experienced a fall are assessed by a physiotherapist. Sensor (buzzer) mats are used for those residents who are at risk of falling. These residents are also encouraged to go to lounge areas during the day so that they can be closely observed.</p>
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<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 that is being implemented by the service. As per DHB request, documented procedures are implemented if a resident is missing including the completion of an accident/incident form.</p> <p>Fifteen accident/incident forms were randomly selected for review. A registered nurse conducts a clinical follow up of each adverse event. Neurological observations are completed for unwitnessed falls. All adverse events reviewed demonstrated that appropriate clinical follow up and investigation took place. Adverse events are also reviewed and signed off by the unit manager. Trends are identified at head office with data benchmarked against the other CHT facilities. This data is available electronically for managers to access.</p> <p>Discussion with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided.</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. Five staff files (two RNs, two HCAs and one activities coordinator) reviewed evidenced implementation of the recruitment process, employment contracts and annual performance appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and remarked that new staff were adequately orientated to the service. Evidence of an orientation programme being completed was sighted in the staff files reviewed.</p> <p>There is an annual education plan that is being implemented that includes in-services and completion of online education modules. The competency programme is ongoing with different requirements according to work type. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Three of the six registered nurses employed have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>CHT policy includes staff rationale and skill mix.</p> <p>The facility is located on two levels with three wings on the ground level (occupancy: eight rest home level residents and nine hospital level) and one wing upstairs (occupancy: six rest home level and four hospital level). Note: the rest home only beds are on the ground level and three of five rest home only beds were occupied.</p>

experienced service providers.		<p>In addition to the unit manager/RN (who works Monday – Friday), there is one registered nurse on every shift, seven days a week. The AM shift is staffed with four HCAs. Three HCAs work on the ground level (two long and one short shift) and one HCA works on the first level (long shift). The PM shift is staffed with three HCAs. Two HCAs work on the ground level (one long and one short shift) and one short shift HCA works on the first level during the PM shift. One HCA covers the night shift.</p> <p>The unit manager reported that extra staff can be called for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents although concerns were expressed regarding cover for the activities programme. Two activities coordinators provide cover seven days a week, although only one activities staff has been available on a part time basis over the recent three-week holiday period. The residents interviewed expressed this as a concern and the HCA's and unit manager interviewed stated that this has caused problems. The unit manager reported that she had no HCA staff that were trained to provide activities. This has been reported as an unusual circumstance and had not been lodged as a finding. The activities staff resumed to seven day a week cover effective 15 January 2019.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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 HCA 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 their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Admission policy and procedures include pre-assessment to ensure CHT can provide safe and appropriate care. Potential residents must be assessed as suitable for rest home or hospital care prior to admission.</p> <p>The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the Age Related Residential Contract (ARCC). Exclusions from the service are included in the admission agreement. All six admission agreements viewed were signed and dated.</p>
Standard 1.3.10: Transition, Exit,	FA	<p>The service has transfer/discharge/exit policy and procedures in place. Residents who require emergency admissions to hospital are managed appropriately and relevant information is</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>communicated to the DHB using the yellow envelope system. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were five residents self-administering on the day of audit and all files demonstrated three-monthly competency assessments signed by both the RN and GP.</p> <p>The facility uses a four-week robotic sachets system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications in the hospital and rest home with senior healthcare assistants acting as second checkers. Medication competencies are updated annually, and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Registered nurses use an electronic medication management system and sign for the administration of medications. Twelve medication charts were reviewed. Medications have been reviewed at least three-monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a contract company to provide all meals. There is a kitchen and cleaning site manager and an assistant cook who, between them, cover all shifts. There is also a kitchenhand during the day. All kitchen staff have current food safety certificates. The site manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from the kitchen for the main dining room and from a mobile hot box to upstairs dining rooms. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on typed lists which are updated with changes. The four-weekly seasonal menu cycle is written and approved by an external dietitian. Resident and family's members</p>

		interviewed are happy with the meals.
<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 reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. 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	Files sampled indicate that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files contain appropriate assessment tools and assessments that have been reviewed at least six-monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. Care plans sampled have been developed on the basis of these assessments.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The six resident files reviewed (four hospital including one on a YPD contract and two rest home) described the supports required to meet the resident's goals and needs. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process.</p> <p>Short-term care plans (STCPs) are in use for changes in health status and had been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, physiotherapist and dietitian. The care staff advise that the care plans are clear and easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Food and fluid charts, staff interviews, observation of staff, equipment and progress notes charts sighted indicate that appropriate interventions are provided as documented in care plans. Registered nurses (including the clinical coordinator) and healthcare assistants report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice

		<p>is available as needed and this could be described.</p> <p>Wound monitoring was in place for six residents with eight wounds (seven skin tears and one stage III facility acquired pressure injury). All wounds had comprehensive assessments and management plans. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses, clinical coordinator and healthcare assistants demonstrated an understanding of the individualised needs of residents and report that two-hourly turns occur. Food and fluid charts are comprehensively completed 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>	FA	<p>There are two activity coordinators who provide an activities programme six hours a day over seven days a week.</p> <p>Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. All long-term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six-monthly when the care plan is evaluated.</p> <p>Group activities reflect ordinary patterns of life and include: regular visits to the local marae, Māori, Anglican and interdenominational church services; exercises; word and quiz games; and art and craft. There are van outings once a week. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There are visiting community groups such as kapa haka groups, school and kindergarten visits. 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>The younger resident is encouraged to remain as active as possible within the community and to engage in age appropriate personal interest activities. Residents and families interviewed commented positively on the activity programme (also refer 1.2.8).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan has been evaluated at least six-monthly or earlier if there was a change in health status. There was at least a three-monthly review by the GP. Short-term care plans reviewed were evaluated and resolved or added to the long-term care plan if the</p>

		problem is ongoing, as sighted in resident files sampled.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</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>	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the dietitian and physiotherapist. Discussion with the registered nurses confirm that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
<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>	FA	There are policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available. The hazard register identifies hazardous substances and staff indicate a clear understanding of processes and protocols. Gloves, aprons, and goggles or facemasks are available for staff.
<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>	FA	The building has a current building warrant of fitness expiring 15th June 2019. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents were observed moving freely around the areas with mobility aids where required. External areas are well maintained. Residents have access to safely designed external areas that have shade. 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</p>	FA	Some bedrooms have shared ensuites and other residents share communal toilets and showers. There are sufficient toilets and showers to meet the needs of the residents. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.

hygiene requirements or receiving assistance with personal hygiene requirements.		
<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	Residents' rooms are of sufficient size to allow care to be provided and the safe use of mobility aids. Staff report that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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	There is a large communal lounge and dining room with several smaller lounges and a smaller dining room. Activities occur in the communal areas. There are spaces where residents, who prefer quieter activities or visitors, may sit. Some lounges open out onto attractive courtyard areas.
<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	All laundry is contracted out, collected and returned daily. There is a comprehensive laundry and cleaning manual. 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' room as sighted on the day of the audit. Cleaning is done by on-site cleaners. There is a sluice room with access from both upstairs and downstairs for the disposal of soiled water or waste. The sluice room is kept closed when not in use.
<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	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. 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 contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. 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>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. Activities staff and the driver of the van also hold first aid certificates.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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 have ample natural light and ventilation. All areas are appropriately heated as confirmed on interviews with staff and residents. The facility has a designated smoking area for resident use.</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>The unit manager (a registered nurse) is the designated infection control coordinator with support from all staff of the quality management committee (infection control team). The infection control coordinator oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to combined infection control and health and safety.</p> <p>The infection control programme has been developed by the CHT management infection control team, is reviewed annually and linked to the quality system.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility.</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>The infection control coordinator has attended external infection control and prevention control education, including CHT infection focus group meetings. Infection control information is entered into an electronic database and extracted for reporting and trend analysis. Reports are reviewed at quality and staff meetings.</p> <p>There is access to infection control expertise within the DHB, wound nurse specialist, public health, laboratory, GPs and an external infection control consultant. The GP monitors the use of antibiotics.</p>
<p>Standard 3.3: Policies and</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines, including</p>

<p>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>defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly by the CHT senior management team.</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 coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>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>The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. A registered nurse is the designated restraint coordinator. There was one (hospital level) resident with restraint and three (hospital level) residents with an enabler. The restraint was a bedrail and the enablers were either bedrails and/or a lap belt.</p> <p>Two enabler files reviewed evidenced that enabler use is voluntary. All necessary documentation had been completed in relation to the enablers as restraints including voluntary/written consent for use by the residents.</p>

		Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Staff education on RMSP/enablers has been provided. Restraint minimisation is regularly discussed in monthly staff meetings.
<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>	FA	The restraint coordinator was on holiday during the audit, so the unit manager was interviewed in her absence. Assessment and approval process for restraint use include the restraint coordinator, registered nurses, resident/or representative and medical practitioner.
<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>	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by the restraint coordinator/RN or a staff RN in partnership with the family/whānau, evidenced in the one restraint and two enabler 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>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	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. There is an assessment form/process that 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. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of</p>	FA	The evaluation of restraint use is scheduled six-monthly. In the restraint and enabler files reviewed, evaluations had been completed six-monthly and involved the resident, family/whānau and restraint

restraint.		coordinator.
<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 Glynavon. Review processes include policy and procedures review, trends analyses 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, 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 1.1.4.2</p> <p>Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.</p>	CI	Both internal and external programmes have been implemented at the facility to better address the needs of the Māori residents.	<p>In 2016, one staff and one family member brought an improvement idea to the attention of the unit manager. The purpose was to assist Māori residents in interacting within the wider Māori community as they considered it important for the health and well-being of the Māori residents. A meeting was subsequently held with the Māori chaplain at the facility and agreement was reached that on the second Sunday of each month, residents would be invited to attend the church service at Otamarakau marae and that a Māori church service would occur on the third Wednesday of each month.</p> <p>As of January 2019, a monthly Māori church service is regularly held on the third Wednesday of each month. This is in addition to other church services (Catholic, Anglican, Baptist and Methodist). Attendance at the church service is high with an average of ten residents (both Māori and non-Māori attending). In addition, five residents regularly attend monthly services at the local marae (two of five residents who identify as Māori and three non-Māori).</p>

End of the report.