

CHT Healthcare Trust - St Johns

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust
Premises audited:	St Johns Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 22 March 2021 End date: 22 March 2021

Proposed changes to current services (if any): The table above states the service provides rest home level care. The service is only certified for rest home-dementia level care, not rest home level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 83



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

CHT St Johns is owned and operated by the CHT Healthcare Trust. The service cares for up to 90 residents across three service levels (hospital, residential disability, and rest home - dementia level care). On the day of the audit, there were 83 residents. The unit manager oversees the service with the support of the area manager and clinical coordinator. Residents, relatives, and the GP interviewed spoke positively about the service provided.

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

The shortfall identified at the previous audit around taking of neurological observations if a resident has had an unwitnessed fall or a hit to the head has been addressed.

This audit did not identify any areas for improvement.

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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CHT St Johns has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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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The team includes managers along with registered nurses, health care assistants, and support staff.

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Appropriate employment processes are adhered to. An education and training programme is established. The roster provides sufficient and appropriate staff cover for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

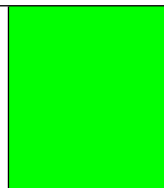
The activity programme is developed to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital, and dementia care residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet prescribing requirements and had been reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being provided 24 hours per day.

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.

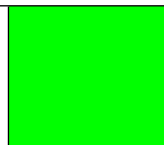


Standards applicable to this service fully attained.

The building has a current BWOF certificate, and all external areas are accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place.

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.

CHT St Johns has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service had two residents using a bedrail as a restraint, and two using bedrails as enablers at the time of audit.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control coordinator (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking with other CHT facilities. There have been no outbreaks since the last audit.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	41	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Managers and staff interviewed included the following: one unit manager, the area manager, clinical coordinator, three registered nurses, five health care assistants from a range of suites, the chef manager, three activities coordinator.</p> <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. Managers and care staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints' register is maintained electronically. Verbal and written complaints are documented and include any concerns identified in the resident/relative meetings and satisfaction surveys. Two complaints have been lodged in 2021 (year-to-date) and four complaints lodged in 2020. All complaints had a documented investigation and the outcome communicated to the complainant by letter or face-to-face meetings. Timeframes for addressing each complaint were compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) were documented.</p> <p>There have not been any complaints lodged with the HDC or other external providers since the last audit.</p> <p>Complaints received and corrective actions are discussed in the quarterly quality meetings. Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the registered nurses (RNs) and management team.</p>

<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>Seven residents using hospital level of care (including two identified as residents with a physical disability), and seven family members interviewed (six with relatives in the dementia unit and one in the hospital) stated they were kept informed of any changes in their relative. They also stated that they were informed in a timely manner when an incident had occurred. All 18 incident forms reviewed confirmed that family were informed of an incident.</p> <p>There are six monthly resident/relative meetings held, and speakers attend to feedback/discuss services such as food service manager. Family newsletters are published quarterly. There are portable phones, skype available on laptops, and Wi-Fi to encourage families and residents to maintain communication with one resident stating that this had helped them through Covid 19 lock down.</p> <p>There is access to interpreters as required. One of the relatives interviewed stated that their family members interpreted whenever that was required.</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 St Johns is owned and operated by the CHT Healthcare Trust. The service provides dementia care, hospital level care and residential disability - physical for up to 90 residents. On the day of the audit, there were 83 residents in total. There were 17 residents requiring dementia care (a 20-bed unit), and 66 hospital level residents including six younger persons under 65 years of age at hospital level with physical disabilities. There were no residents under a respite care or under a medical contract. Residents in the hospital, apart from the six under a residential physical disability care contract are under the Aged Related Care contract.</p> <p>CHT has an overall business/strategic plan that includes the values and vision of the organisation: compassion, companionship, care, comfort and connected. The area manager reports to the CEO at head office, and they meet to discuss the strategic plan. This is also discussed with the unit manager with a business plan documented. Goals for the business plan 1 April to 31 March 2021 are around meaningful and activities connections with communities, having a resident focused experience, robust leadership and system stewardship, health, and safety, and ensuring efficient and effective processes. to discuss the business and organisational risk management plan. The plan has been reviewed at least quarterly as documented in the unit performance management plan with evidence of progress against goals.</p> <p>The unit manager/registered nurse has been in the role at St Johns for 15 years with 30 years' experience in aged care services. The unit manager is supported by an area manager (present during the audit), who has been in the role for four years and has five years' experience in aged care, and a clinical coordinator who has been in the role for nine years with 17 years' experience in aged care services. The unit manager reports to the area manager on a variety of operational issues. The area manager visits the site fortnightly.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months including attending provider cluster meetings, aged care manager workshops, employment law and health and</p>

		safety.
<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>	FA	<p>There is a unit business/strategic plan that includes quality goals and risk management plans. The unit manager is responsible for providing oversight of the quality programme and was able to describe the value and detail of the programme. The quality and risk management programme is designed to monitor contractual and standards compliance.</p> <p>A document control system is in place with all quality documents reviewed on an annual basis by area managers. New policies or changes to policy are sent to the unit and communicated to staff, as evidenced in meeting minutes.</p> <p>Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints, and internal audit outcomes. Staff interviewed confirmed they are kept informed on quality data, trends and correctives actions at the quarterly combined quality/health and safety meetings. There are staff household meetings. Meeting minutes are made available to staff.</p> <p>The area manger completes six monthly internal audits against core standards, restraint, and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off when completed.</p> <p>Annual resident/relative surveys are completed, and the results fed back to participant through newsletters and resident/relative meetings. The 2020 results showed a high level of satisfaction over all domains with no consistently raised areas for improvement.</p> <p>The service has a health and safety programme in place. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety is included in the combined quality/health and safety meetings. There are three health and safety representatives. One representative (interviewed) has completed stage two health and safety representative training and was able to describe their role as per legislation and the job description. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling and there is ongoing online training for all staff annually. Staff also have training around moving and handling annually facilitated by the physiotherapist. Hazard identification forms are implemented. There is a current hazard register in place. All contractors complete an induction to the facility.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> <p>The service works with the district health board to improve practice. An example is the engagement with the POI programme which is an initiative around palliative centric care planning.</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>Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. Eighteen resident related incident reports for the last quarter 2020 and 2021 were reviewed. All reports evidenced that family had been notified and appropriate clinical care was provided following an incident, and all neurological observations were completed for all unwitnessed falls or where a resident sustained a head injury. Documentation including care plan interventions for prevention of incidents, was fully documented.</p> <p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality/health and safety, clinical meetings, and handovers, including actions to minimise recurrence. Staff interviewed confirmed incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two Section 31 notifications since the previous audit around an unexpected death and one unstageable pressure injury.</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 policies to support recruitment practices including relevant checks to validate the individual's qualifications, experience, and veracity. Six staff files (one clinical coordinator, two RNs, two healthcare assistants, one activity coordinator/health and safety representative) were reviewed, and these contained all relevant employment documentation and job descriptions. Current practising certificates were sighted for the RNs, and allied health professionals. All staff signed a code of conduct, code of confidentiality and information technology policy. Performance appraisals were up to date.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Two new staff employed since the last audit confirmed that they had a comprehensive orientation audit including being located with a buddy who supported them at all times during the first week.</p> <p>The service uses an external on-line training programme for most training with this programme offering the compulsory education requirements. There are additional on-site clinical in-services and external education offered. Staff individual records of training is maintained. Staff complete competencies relevant to their role including medication, hand hygiene and safe manual handling. CareerForce assessors support health care assistants (HCAs) progress through the CareerForce units. There are 18 HCAs who work in the dementia suites. Twelve HCAs work in the dementia unit and all have completed dementia unit standards, bar one who is new to the service. Overall, there are 25 HCAs who have completed level 4 training CareerForce, 14 who have completed level three training, two with level 2 and 17 with level 1 training. Nine of the twelve RNs have completed interRAI training.</p> <p>Registered nurses and HCAs have the opportunity to attend nurse specialist study days at the DHB.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>CHT organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The unit manager and clinical coordinator work fulltime Monday to Friday and are on call 24/7. They are supported by an area manager and 12 registered nurses. The service is actively recruiting for casual RNs and HCAs to cover for periods of leave/sickness. The same bureau nurses are requested to cover for RN leave. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. The registered nurse on each shift is aware that staff working short shifts or float shifts can be extended to meet increased resident requirements.</p> <p>The facility is divided into 11 suites. Suites 1-5 have eight beds each, suite 6 is reception/administration, suites 7, 10 and 11 (upstairs) have 10 beds and suites 8 and 9 (dementia care) have 10 beds each. There are three unoccupied beds in the dementia units and six spread across the suites (hospital level of care).</p> <p>There are three RNs on morning shifts that are allocated to the suites as follows: one to suite 2 to 5; one to suite 1, 7, 11; one (clinical coordinator) to suite 8, 9, 10. A registered nurse is rostered from 12PM to 8.30PM and they take over from the clinical coordinator in the dementia suites.</p> <p>There are two RNs on the afternoon shift, and they split the suites between them. There is one RN on night shift to cover the suites.</p> <p>There is an HCA shift in the dementia unit. There is a 'float' between the units in the morning (8AM-1PM) and an activities coordinator in the dementia unit (1PM to 7PM).</p> <p>In the hospital in the 10 bed suites (7, 11, 10), there is one HCA and a 'float' from 8AM to 1PM.</p> <p>For suites 1-5 (eight beds each suite), there is an HCA in each in the morning with three 'floats' (8AM to 1PM). All hospital suites have an allocated HCA with two 'floats' on a short shift between allocated suites.</p> <p>Younger people are placed in suites within close proximity of each other or with other residents with 'like' abilities.</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</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on-site. All clinical staff (RNs, med-comp caregivers) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and a caregiver interviewed could describe their role regarding medication administration. The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart on the electronic system and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, and the</p>

<p>guidelines.</p>		<p>temperatures were within acceptable ranges. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Twelve electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals at CHT St Johns are all prepared and cooked on site. The kitchen was observed to be clean, well-organised and a current approved food control plan was in evidence. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The chef manager (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the servery. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. There is a food control plan expiring 7 April 2021.</p> <p>The residents interviewed were satisfied with the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</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>	<p>FA</p>	<p>The registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents' mobility and transfer needs as required.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound</p>

		<p>monitoring occurred as planned and is documented on both a paper based wound log and the Vcare system. There were 15 ongoing wounds including four lesions, seven skin tears, one chronic ulcer, one haematoma, a stage one and a stage two pressure injury. There service has access to a wound nurse specialist as required for input and advice as required and this was in evidence with the chronic ulcer.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food, and fluid, turning charts, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required. Documentation related to nine incidents where a resident had had an unwitnessed fall confirmed that neurological observations had been taken as per policy. The shortfall identified at the previous certification audit around documentation of neurological observations following unwitnessed falls or if a resident has hit their head has been addressed.</p> <p>Care plans have been updated as residents' needs changed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are five activity coordinators who provide a seven-day programme across all care levels. A company diversional therapist (DT) oversees the activity programmes. The activity coordinators attend CHT workshops and on-site in-services. Of the three activities coordinators interviewed on day of audit, one was a qualified DT, and one was working towards their DT qualifications. All hold current first aid certificates.</p> <p>The programme is planned monthly and includes CHT minimum requirements for the activities programme, including themed cultural events. Activities programmes are displayed on noticeboards around the facility and a monthly calendar is delivered to each individual resident. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One-on-one time is spent with residents who are unable to actively participate in the activities.</p> <p>A variety of individual and small group activities were observed occurring in the care units at various times throughout the day of audit. Entertainment and outings are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed.</p> <p>An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment, and outings. Resident meetings are held monthly, and family are invited to attend. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme.</p>

		Residents interviewed spoke positively about the activity programme provided.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Five long-term care files sampled of permanent residents contained written evaluations completed six-monthly. The other one file was a relatively new admission and was not due for evaluation at the time of audit.</p> <p>Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a building warrant of fitness which expires 19 October 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, the next checks being due October 2021. Items of medical equipment are calibrated annually and are next due to be checked August 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, decked areas and gardens are well maintained. All outdoor areas have attractive features and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</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 surveillance programme is organised and promoted centrally from CHT head office. Effective monitoring is the responsibility of the infection control nurse (RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the RN meeting and monthly staff meetings.</p> <p>The overall effectiveness of the surveillance program is evaluated annually by the CHT infection control committee. All meetings held at CHT St Johns include discussion on infection prevention control. The infection control programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and are analysed at site level using Vcare. There have been no outbreaks since the last audit.</p> <p>An organisational Covid-19 strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE, these details being passed on to families via</p>

		email, skype and in writing. During Covid lockdown the service implemented weekly staff briefings which allowed for updates, education and discussion. All visitors are required to provide contact tracing information.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There are two residents using bedrails as a restraint and two using a bedrail as an enabler. Consents were appropriately signed; assessments were completed, and risks were identified for the residents using restraints. Staff receive training/education on restraint/enablers and restraint is discussed as part of the quality, health and safety meetings and the clinical and staff meetings. A registered nurse is the designated restraint coordinator. They have been in the role for 15 years.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.