# CHT Healthcare Trust - Amberlea Hospital and Rest Home

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Amberlea Hospital and Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 April 2016 End date: 20 April 2016

**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:** 69

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

## General overview of the audit

CHT Amberlea is owned and operated by the CHT Healthcare Trust. The service provides care for up to 72 residents requiring hospital/medical and rest home level care. On the day of the audit, there were 69 residents. The service is overseen by a unit manager, who is well qualified and experienced for the role and is supported by a clinical coordinator and the area manager. Residents and the GP interviewed spoke positively about the service provided.  
This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.   
This audit has identified areas requiring improvement around meeting minutes, incident reporting for pressure injuries, staff reference checks, staff orientations, GP initial assessments, aspects of medication management and care interventions.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | All standards applicable to this service fully attained with some standards exceeded. |

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

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The unit manager is supported by the area manager, a clinical coordinator, registered nurses and healthcare staff. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Resident meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. A registered nurse follows up incidents and accidents that are reported. A comprehensive education and training programme has been implemented with a current training plan in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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

The clinical coordinator manages entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframe. Care plans are based on the InterRAI findings and other assessments. Residents and relatives interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews the residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The integrated programme is offered in lounges throughout the facility and meets the individual recreational preferences and abilities of both groups of residents.

Medicines are stored and managed appropriately in line with legislation and guidelines. Staff responsible for the administration of medications attend annual medication education. General practitioners review residents’ medications at least three monthly.

Meals are prepared on site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. Reactive and planned maintenance is in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and all have their own toilet and hand basin and some with full ensuites. There are adequate numbers of communal toilets and showers. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are communal dining rooms and lounges in the three wings. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and laundry contractors are providing appropriate services. Emergency systems and equipment are in place in the event of a fire or external disaster. There is a first aider on duty at all times.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

Amberlea hospital has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint and two residents with an enabler. Enabler use is voluntary.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. The surveillance aspect of the programme has been recently implemented. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are beginning to be acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 37 | 0 | 5 | 2 | 0 | 0 |
| **Criteria** | 2 | 82 | 0 | 6 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (five healthcare assistants, three registered nurses (RN), two activities staff, one clinical coordinator, one area manager and one unit manager) confirm their familiarity with the Code. Interviews with ten (six rest home and four hospital) residents and four families (three hospital and one rest home) confirm the services being provided are in line with the Code. The Code is discussed at resident and quality/health and safety meetings. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs for written general consents. Copies of EPOA are held on resident files where appropriate. Cardiopulmonary resuscitation status is evident in the nine resident files reviewed (five hospital and four rest home). There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members confirmed they were involved in decisions that affect their relative’s lives. All resident files contained a signed admission agreement. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents and family members interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Verbal and written complaints are documented. Twelve complaint forms were reviewed (since April 2015). All 12 complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the code of rights on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code of Rights. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | 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.  A policy describes spiritual care. Church services are conducted in the facility regularly. All residents interviewed indicated that resident’s spiritual needs are being met when required.  Staff have received training around recognising abuse and neglect and staff interviewed were conversant around this. There have been no reported incidents of abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. One resident identified as Māori on the day of the audit.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service has established cultural policies aimed to help meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.  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. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that aligns with the health and disability services standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.  Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | CI | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed (a sample from April 2016). The forms included a section to record family notification. All ten forms indicated family were informed or if family did not wish to be informed. Residents and family members interviewed confirmed that relatives are notified of any changes in their family member’s health status.  The service has exceeded the required standard over the communication methods used to provide information to new residents and their families. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Amberlea hospital is owned and operated by the CHT Healthcare Trust. The service provides hospital/medical and rest home level care for up to 72 residents. On the day of the audit, there were 69 residents. This includes 27 rest home level residents and 42 hospital level residents. All residents are under the aged related residential care contract. All rooms are dual purpose. The unit manager is a registered nurse and maintains an annual practicing certificate. She has been at Amberlea for three years and in the unit manager role for 18 months. The clinical coordinator has been in the role for 28 months. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Amberlea has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The unit manager has completed in excess of eight hours of professional development in the past 12 months. |
| Standard 1.2.2: Service Management  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. | FA | In the absence of the unit manager, the area manager is in charge with support from the senior management team, the clinical coordinator and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is an organisational business/strategic plan that includes quality goals and risk management plans for Amberlea. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level, with input from facility staff every two years. New/updated policies are sent from head office, with a draft policy including InterRAI assessment requirements. Staff have access to manuals. Resident/relative meetings are held quarterly. Restraint and enabler use is reported within the quality meetings.  Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. There is evidence of comprehensive data analysis for falls and UTIs and data analysis at an organisational level that is provided to the facility for other incidents and infections. Quality/health and safety meetings (attended by all staff) document the numbers of types of incidents for the period but no discussion around trend analysis. The area manager completed a comprehensive internal audit in March 2016 covering all aspects of the service. Following this a number of corrective action plans were developed, all of which have been actioned and implemented. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Results for the 2015 survey reflected satisfaction with services provided. |
| Standard 1.2.4: Adverse Event Reporting  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. | PA Low | There is an accidents and incidents reporting policy. The manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. A registered nurse conducts clinical follow up of residents. Ten incident forms sampled from April 2016 included appropriate follow-up by a registered nurse and investigation of incidents to identify areas to minimise the risk of recurrence. However, pressure injuries had not been reported on incident forms. Incidents/accidents are collected for data analysis (link 1.2.3.6). Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notifications have been made to HealthCERT and the DHB. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (the clinical coordinator, the activities coordinator, one registered nurse and three healthcare assistants) and these evidence appropriate employment practices except that that reference checks were not always completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Not all staff files sampled had completed orientations documented. The in-service education programme for 2015 has been completed and a plan for 2016 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is on duty at any one time. Senior staff on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical coordinator screens all potential residents prior to entry to ensure the service can meet the residents assessed needs. The admission agreement aligns with the requirements of the ARCC agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policies and procedures comply with medication legislation and guidelines. The RN on duty checks medications delivered against the medication chart. Registered nurses and medication competent HCAs administer medications. Not all RNs have completed medication competencies annually. Medications are stored correctly. The medication fridge is monitored daily. All eye drops had been dated on opening. There were no residents self-medicating on the day of audit. Standing orders are not in use.  Eighteen medication charts were reviewed. Medication charts are pharmacy generated and met the legislative requirements. All medication charts had been reviewed at least three monthly by the GP. A review of administration charts identified three medications had not been administered as prescribed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | There is a fully functional kitchen and all food is cooked on site by contracted kitchen staff. The kitchen manager (qualified cook), is supported by another cook and kitchen hand on duty each day. The contracted dietitian, in consultation with the CHT dietitian, has reviewed the menu. A resident nutritional profile is developed for each resident on admission and provided to the kitchen manager. Dietary needs including modified meals are accommodated. Special diets include gluten free and REAP fortified foods. The kitchen manager (interviewed) was able to describe alternative meals offered for residents with dislikes and the Replenish Energy and Protein (REAP) programme for weight loss. Resident likes and dislikes are known. Meals are plated from the bain marie in the main kitchen and delivered in hot boxes to the dining/kitchenette area in each of the three wing.  The kitchen staff have completed food safety and chemical safety training.  The temperatures of refrigerators and freezers in the main kitchen are monitored and recorded. Each wing has a functioning kitchenette with dishwasher and fridge. Temperatures have not been monitored for the kitchenette fridges. Temperatures are monitored on inward chilled goods. End cooked temperatures are monitored for each meal. All dry goods were dated, in sealed containers and stored off the floor. All perishable foods in the main kitchen and kitchenette fridges were dated. A cleaning schedule has been maintained.  Residents commented positively on the meals provided and have the opportunity to feedback on the service through resident meetings and surveys. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The service records the reasons for declining service entry to residents should this occur, and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. InterRAI assessments including risk assessments are completed on admission. Overall the outcomes of assessments were reflected in the long-term care plans in resident files reviewed. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed did not all describe the support required to meet the resident’s goals and needs as identified through the assessment process (link 1.3.6.1). Residents and relatives confirmed they were involved in the care planning and review process. There is documented evidence of resident/relative involvement in the development of care plans. Short-term care plans were in use for changes in health status. Care staff interviewed reported the care plans are readily available and they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) (including the clinical coordinator) and HCAs, follow the care plan and report progress against the care plan at each shift at handover. Care plans reviewed did not all document interventions for the management of hypoglycaemia/hyperglycaemia where these were required.  Turning charts, food and fluid charts and behaviour monitoring charts were available. Evidence was missing for some required weight monitoring.  When a resident’s health changes the RN initiates a GP or nurse specialist consultation or allied health advice. If external medical/specialist advice is required, this will be initiated by the GP. The residents interviewed state the support received meets their expectations. Relatives interviewed confirmed the care of their relatives meet their expectations.  Sufficient continence products were sighted. Resident files include a continence assessment and plan as applicable. Specialist continence advice is available as needed and this could be described.  Staff have access to sufficient dressing supplies. Wound assessments, wound management plans and wound evaluations were in place for 12 minor wounds including skin tears. There were six pressure injuries (two community acquired) being treated on the day of audit. Wound care documentation does not reflect the current status of the pressure injuries. Not all pressure injuries had wound assessments completed. The RNs have access to specialist nursing wound care management advice through the district health board (DHB). Appropriate pressure injury interventions were documented in the care plans of residents identified as high risk of pressure injury. |
| Standard 1.3.7: Planned Activities  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. | FA | There are three activity coordinators employed for a total of 53 hours per week. An HCA is employed for 4 hours per week to provide music therapy. The CHT diversional therapist oversees and supports the activity team. The activity coordinators attend regional workshops. They attend on-site education; have current first aid certificates and hold have completed aged care education modules.  The activity programme is provided Monday to Sunday and activities occur in lounges upstairs and downstairs. The activities provided meet the recreational preferences and abilities of the resident groups and include art and crafts, exercises, walks, ‘brain fit’ programme and sensory activities. Activities reflect ordinary patterns of life and include planned visits into the community such as shopping, cafes, picnics and the RSA. Volunteers are involved in the activity programme with piano playing, music, and arts and crafts weekly. An interactive project is an ongoing mural using a number of textures and designs.  Church groups visits twice monthly to provide church services and fellowship. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. A hired van is used for resident outings.  Each resident/family had completed a lifestyle questionnaire. The individual activities assessment is incorporated into the InterRAI assessment process and written-up in the overall care plan that is reviewed six monthly.  Residents interviewed commented they have the opportunity to provide suggestions for activities through the resident meetings and surveys. They commend positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. Evaluations are documented. Changes in health status are updated on the care plan. Evaluations record if the resident goals have been met or unmet. Six monthly reassessments have been completed by RNs using InterRAI LTCF for all residents and for those who have had a significant change in health status. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples where a resident’s condition had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data and product sheets were available. Relevant staff have completed chemical safety. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 27 May 2016. The facility is a two level building with lift and stair access. There is a part time maintenance person who completes the monthly planned maintenance schedule for the internal and external building. Maintenance requests are recorded and addressed. Essential contractors are available 24 hours.  Electrical equipment is tested and tagged two yearly. Clinical equipment is checked and calibrated annually. Hot water temperatures are monitored in each wing and maintained below 45 degrees Celsius.  The facility has sufficient space for residents to mobilise using mobility aids. There is sufficient space in communal areas for residents to be safely seated in hospital lounge chairs. External areas including grounds and deck areas are well maintained and easily accessible. External areas provide seating and shade.  Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms on the first floor have their own toilet and hand basin. There are adequate communal showers with vacant/engaged signs and privacy curtains. All resident rooms on the ground floor have full ensuites. There are an adequate number of communal toilets near communal areas.  Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents’ rooms are dual purpose and allow for the provision of hospital level care including the safe use and manoeuvring of mobility aids and hoists within the room. Residents are encouraged to personalise their bedrooms as viewed on the day audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include a large main open plan lounge and dining/kitchenette area. Each wing has a smaller dining/lounge area with functional kitchenette. The upstairs and downstairs lounges are used for activities. Several seating alcoves and lounges provide residents with a relaxing view of the bay. Residents commented positively on the environment. Communal rooms are easily accessible. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry and personal clothing with the exception of woollens and delicates are laundered off site. Dirty laundry is collected daily through a designated exit point with daily delivery of the clean laundry and clothing. A laundry project has been implemented to reduce the number of lost clothing and bedding. Residents interviewed were satisfied with the laundering and timely return of their clothing. Two cleaners are contracted by an external provider Monday to Friday and one on the weekends. The cleaning trolleys were well equipped and stored in designated locked cleaner’s cupboards. The staff have access to a range of chemicals, cleaning equipment and protective clothing. The chemical provider monitors the use and effectiveness of laundry and cleaning chemicals. The facility was well maintained and clean on the days of audit. Residents interviewed were satisfied with the cleanliness of their rooms and environment. The standard of cleanliness and laundry process is monitored through the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The fire evacuation plan was reviewed and approved by the fire service 31 January 2014, following building alterations. 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 last February 2016. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking (two barbeques). A generator is supplied through a contracted service when required. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is on duty at all times.  There are call bells in the residents’ rooms, bathrooms/toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The call bells are connected to walkie-talkies that staff carry.  The building is secure afterhours with doorbell access at the main entrance and keypad access to the back entrance. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. The facility has underfloor heating with individual thermostats in resident rooms. |
| Standard 3.1: Infection control management  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. | FA | Amberlea hospital has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and all staff as the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Amberlea hospital is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  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. | FA | There are CHT infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are notified of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit. The service has exceeded the standard around improving outcomes for a group of vulnerable residents identified in surveillance data. |
| 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 were no residents with restraint and three residents with an enabler. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality/health and safety meetings. A registered nurse is the designated restraint coordinator. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality/health and safety meetings minutes (which are attended by all staff) reflect that previous issues are addressed and that complaints, falls and infection trends are discussed. The minutes do not reflect discussion around data analysis outcomes for incidents/accidents. | Quality/health and safety meeting minutes document numbers of incidents by type for the period but no discussion around the trends or data analysis. Health care assistants confirmed this finding. | Ensure that all service providers are informed of the results of accident/incident data analysis and evaluations.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Incidents/accidents are collected for data analysis (link 1.2.3.6). When a pressure injury occurs, the registered nurse completes a pressure injury report form. These forms are not included in incident data and pressure injuries have not been reported as incidents. | Six current pressure injuries and two healed pressure injuries identified had not been included in the incident reporting system or incident data. | Ensure all pressure injuries are captured as incidents and included in incident data analysis  60 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Seven staff files were sampled. Each of the files contained an employment contract, police checks, interview documentation, an application, and a position description. Five of the staff files sampled contained a reference check. | Two of seven staff files sampled did not contain a documented reference check. | Ensure that a reference check is completed and documented for all new staff employed.  90 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | CHT Amberlea has a comprehensive orientation programme and new staff are ‘buddied’ prior to demonstrating competencies to work unsupervised. Complete orientation documentation was sighted in two of seven staff files sampled. | Three of seven staff files sampled did not have a documented orientation and a further two files did not have the orientation documentation fully completed. | Ensure that all new staff completes an orientation programme.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Eighteen medication charts and corresponding signing administration forms were reviewed. Fifteen signing sheets evidenced medication was given as prescribed. | Three medications for three residents had not been administered as prescribed by the GP. | Ensure all medications are administered as prescribed.  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Comprehensive medication competencies are required to be completed annually by all RNs and some senior HCAs. All HCAs administering medications have completed an annual competency. Not all RNs have completed their annual competencies. | Seven RNs have not completed annual competencies. | Ensure all RNs complete medication competencies annually.  30 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Each wing has a kitchenette in the open plan dining/lounge areas. Meals are served from a bain-marie. There is a dishwasher, fridge, tea making facilities and food items available. Fluids and protein drinks are delivered to the fridges daily. The fridge temperatures have not been monitored in the kitchenettes. | The three kitchenette fridges contain resident food items, perishable goods and protein drinks. There was no evidence of temperature monitoring for these fridges. | Ensure all fridges containing resident foods and perishable goods have temperatures monitored and recorded.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Nine resident files (five hospital and four rest home) were reviewed. Registered nurses (RN) had completed initial assessments and initial care plans within 24 hours of admission in all resident files reviewed. InterRAI assessments and long-term care plans were completed within 21 days of admission. Long-term care plans reviewed were evaluated at least six monthly or earlier as required due to health changes In seven of nine resident files reviewed, the GP had completed admission visits within the required timeframe. | Two resident files (one hospital and one rest home) did not evidence GP admission visits within two working days. | Ensure GP admission visits occur within two working days.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The service has a REAP (replenish, energy and protein) food fortification programme to manage weight loss. Residents at risk of weight loss or losing weight are commenced on the programme. Weight loss reports monitor the resident’s progress. Not all weights are monitored as instructed in the care plans. All minor wounds have individual wound assessments and evaluations in place. Not all pressure injuries have wound assessments and evaluations in place. Care plans reviewed documented interventions for all required issues but did not contain detail around the management of hyper and hypo glycaemia. | 1) Weights had not been completed at the required frequency documented in care plans for three residents (two rest home and one hospital resident). There was no weight loss report for one rest home resident commenced on REAP. 2) The weight loss report has not been updated for one hospital resident to reflect recent weight loss. 3) There are no documented interventions for the management of hypoglycaemia and hyperglycaemia for one rest home resident on insulin. 4) One hospital resident with three pressure injuries does not have wound assessments and evaluations for each pressure injury. There is no wound assessment for one pressure injury for the same resident. | 1) Ensure weight monitoring is completed as documented in the care plans. 2) Ensure weight loss reports are implemented/reviewed to reflect the resident’s nutritional status. 3) Document interventions for the management of hypoglycaemia and hyperglycaemia, for insulin dependent residents. 4) Ensure each pressure injury has individual wound assessments and wound evaluations.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | CI | Residents and family members interviewed report that staff finds common areas of interest to engage residents in communication. They report that information provided to them is careful and clearly explained in a manner that is appropriate to their comprehension. | Following a complaint in 2015, the service determined that while all required information was being provided to new residents and their families, some of this was not easy to refer back to. They implemented a quality plan to better meet the information needs of new residents and their families.  A new welcome pack was designed in simple, conversation style language in an easy to read format, as an induction and orientation resource and something residents and families can keep and use as a reference in the first few weeks they are in residence. The intention was to ease the transition into residential care, to allay fears and anxiety associated with the unknown.  Following the introduction of the booklet in June 2015 survey results for families and residents show an increase in all ‘personal issue’ areas, particularly staff keeping them informed, helpfulness of staff arranging services and explanation of fees and charges. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | All infection data is collected and analysed to identify trends and where trends are identified, actions are implemented to address the trends. | In June 2015, the service identified through infection surveillance data that a group of five residents were experiencing recurrent UTIs. Staff and management researched potential interventions and a bladder support programme was introduced for these residents that included a PowerPoint presentation and in-service class being written by a registered nurse and the clinical coordinator, to support the programme and educate all care staff. A comprehensive algorithm was designed for the skilled nursing staff to follow, detailing the course of treatment once a urinalysis dipstick indicates probable UTI. Consent from the residents & their family was obtained and the contracted physician is supportive of the programme and does the prescribing.  Prior to the introduction of the initiative, the five residents had experienced 21 UTIs collectively in the previous five months. These five residents have had four UTIs (between them) in the seven months since the programme commenced. |

End of the report.