

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](#).

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: 17 April 2019 End date: 18 April 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	59

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

CHT Amberlea is owned and operated by the CHT Healthcare Trust. The service provides cares for up to 70 residents requiring hospital and rest home level care. On the day of the audit, there were 59 residents. The service is overseen by a unit manager, who is a registered nurse and well qualified and experienced for the role and is supported by 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 improvements are required around aspects of medication management and care plan evaluations. The service is commended for initiatives in the activities programme.

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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The service endeavours to provide care in a way that focuses on the individual residents' quality of life. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented. 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 service implements the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to focus group meetings that include discussion of all aspects of the quality programme. An annual resident/relative satisfaction survey is completed and both this, and interviews with residents and family, confirmed satisfaction with the service. Quality and risk performance is reported to the area manager and to the management team at head office.

There are human resources policies to guide practice and an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. The unit manager is supported by the area manager, an acting clinical coordinator, registered nurses and health care staff. 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.
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The unit manager takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. A registered nurse completes initial assessments, including interRAI assessments. The registered nurses complete care plans and long-term care plan evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. They are clearly documented, and healthcare assistants report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. 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. Residents interviewed were satisfied with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. 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 movement of residents around the facility using mobility aids. There are communal lounges and dining areas in each of the three wings. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Emergency systems and equipment are in place in the event of a fire or external disaster. There is always a first aider on duty.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Amberlea Hospital and Rest Home has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there was one resident using a lap belt for safety, identified as a restraint, and no 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.
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Infection control management systems are documented to minimise the risk of infection to residents, staff and visitors. The infection control programme is implemented as per policy. The infection control officer (registered nurse) uses the data and information including results of audits of the facility, hand hygiene and surveillance of infection control events to determine infection control activities, resources and education needs. Staff receive ongoing training in infection control.

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	47	0	1	1	0	0
Criteria	1	97	0	1	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (five healthcare assistants, five registered nurses (RN), one activities coordinator, one acting clinical coordinator, one area manager and one-unit manager) confirmed their familiarity with the Code. Interviews with eight residents, (five rest home and three hospital, including one using interim care funding), and five families (two hospital and three rest home) confirmed the services being provided are in line with the Code.</p> <p>The Code is discussed at the resident meetings with the Health and Disability advocate providing training to staff around the Code.</p>
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	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Eight resident files sampled (five hospital including one on an interim care contract and three rest home) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed, confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All eight resident files sampled had a signed admission agreement, signed either on or before the</p>

informed consent.		day of admission and consents.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate. The advocate from the Nationwide Advocacy service visits the service once or twice a year to provide training to staff.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service aids ensure that the residents can participate in as much as they desire and can safely do.</p> <p>Resident meetings are held at regular intervals. Family are encouraged to discuss any issues with the registered nurses, acting clinical coordinator or the unit manager who has an open-door policy. Family interviewed, confirmed that they do discuss any issues with managers or staff.</p> <p>The service encourages the community to be a part of the residents' lives in the service, with visits from entertainers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints procedure to guide practice. The unit manager has overall responsibility for managing the complaints process at the service. A record of all complaints is maintained on VCare (electronic register) and in a hard copy manual. The register includes relevant information regarding the complaint, including date of resolution. Verbal complaints are included, and actions and response are documented. Complaints are reported to head office and discussed monthly. The area manager also stated that they are aware of any complaints as these arrive, and are actively engaged in any complaints that may come from an external authority.</p> <p>The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. There is a 'post box' at reception where complaints can be posted with this cleared daily Monday to Friday.</p> <p>Discussion with residents and relatives confirmed they were provided with information on the complaint</p>

		<p>process. Complaint forms were visible for residents/relatives in various places around the facility. There has been one complaint from an external authority since the last audit. The Ministry of Health requested follow-up of aspects of a complaint related to transfer of care. There were no identified corrective actions related to this complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) on display in the facility and leaflets are available in the foyer. The service can provide information in different languages and/or in large print if requested.</p> <p>Information is given to next of kin or enduring power of attorney (EPOA) and to the resident on admission to the service. The unit manager confirmed that they discuss the information pack with the resident and the family/whānau as part of the entry process. The information pack includes a copy of the Code.</p> <p>The quarterly resident meetings are an opportunity for residents to discuss application of the Code and for staff to confirm access to advocacy services. Residents and relatives interviewed confirmed information has been provided around the Code and the complaints process.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>A policy describes spiritual care. Church services are conducted in the facility two weekly with the activities programme. The chaplain interviewed, confirmed that any resident or family member was able to attend the services. All residents interviewed indicated that residents' spiritual needs are being met when required, either through the church service offered, by attending community services and/or through the 'soup for the soul' messages provided through the activities programme.</p> <p>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. The general practitioner, chaplain and care staff interviewed confirmed that there was no evidence of any abuse or neglect at the facility.</p> <p>The service encourages residents to continue to be a part of the community and engage in activities in the community whenever possible. They also encourage family and visitors into the facility.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no residents who identify as Māori on the day of the audit.</p> <p>Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process and review. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. Staff interviewed could describe how they supported a resident who identified as Māori in the past and described asking family and the resident what cultural cares and activities they would like.</p> <p>Family/whānau involvement is encouraged in assessment and care planning. Visiting is encouraged and staff can describe the importance of family for Māori.</p> <p>The service can access kaumātua and the kuia through the district health board if they require extra support, although the unit manager stated that family would normally be the ones who would provide on-site support for individual residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau. Values and beliefs have been discussed at the initial assessment and care planning meeting and then incorporated into the care plan. Six monthly care planning meetings are scheduled to assess if needs are being met. Family are invited to attend.</p> <p>Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are implemented policies and procedures to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment or financial exploitation. Professional boundaries are reconfirmed through education and training sessions and staff meetings, and the unit manager stated that performance management would address any concerns if there was discrimination noted.</p>

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>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.</p> <p>The area manager and unit manager work closely together to achieve objectives and to improve the service. Improvements that enhance the lives of residents and support staff development have been introduced, including the introduction of an on-line training programme; the implementation of Qlik which allows the unit manager to access real time data that can be used in improving the quality of the service; a change to providing a bedside handover with the incoming and outgoing registered nurses; improvements made to the activity programme and the introduction of focus group meetings.</p> <p>Residents, relatives and the general practitioner interviewed were satisfied overall with the service provided, although there were some comments made for improvements.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Documentation of accidents, incidents and complaints; and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and to ensure that full and frank open disclosure occurs.</p> <p>Fifteen incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms confirmed that family were informed of any incident. Residents and family members interviewed confirmed that relatives are notified of any changes in their family member's health status.</p> <p>The service circulates seasonal newsletters to residents and family, and family members are sent the meeting minutes of resident meetings.</p> <p>A welcome pack is provided to potential residents and family on entry to the service or when there are enquiries into the service. Residents and family interviewed stated that this was useful.</p> <p>There are no residents with English as a second language. There are staff on site who can speak other languages and those interviewed stated that they would communicate with a resident in their language if they could. Staff can access interpreting services if required through a nationwide interpreting service or through the district health board.</p>
Standard 1.2.1: Governance The governing body of the	FA	<p>Amberlea Hospital and Rest Home is owned and operated by the CHT Healthcare Trust. The service provides hospital, medical and rest home level care for up to 70 residents. On the day of the audit, there were 59 residents. This includes 23 residents requiring rest home level care and 36 residents requiring</p>

organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		<p>hospital level care (including one using interim care funding). All residents except one are under the age related residential care contract. All rooms are dual purpose.</p> <p>The unit manager is a registered nurse who maintains an annual practicing certificate. The unit manager has been in the role for two years with 15 years' experience in aged care. The unit coordinator is supported by the area manager who is a registered nurse, and has extensive experience in management and nursing, including intensive care nursing, duty care manager at a district health board and manager in aged care. The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p> <p>There is an acting clinical coordinator who has been in the role for three months since the previous clinical coordinator left, and has been in the service as a registered nurse for just over three years. The unit manager reports to the area manager two weekly or as required, on a variety of operational issues.</p> <p>CHT has an overall business/strategic plan and Amberlea Hospital and Rest Home 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.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>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. Currently a registered nurse has been put in place as acting clinical coordinator with support from the unit manager in the absence of the clinical coordinator.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The unit manager advised that they are responsible for providing oversight of the quality programme. There is an organisational business plan/unit manager performance plan, 1 April 2019 to 31 March 2020 that cascades from the strategic plan. This includes key performance indicators, goals, actions, timeframes and accountabilities. A review of the previous plan was completed.</p> <p>The service's policies are reviewed at national level, with input from facility staff every two years. New/updated policies are sent from head office, with a draft policy including interRAI assessment requirements. Staff have access to manuals.</p> <p>The quality programme includes an annual internal audit schedule that is being implemented. Audit summaries and corrective action plans are documented where a non-compliance is identified. Issues</p>

		<p>and outcomes are reported through the focus group meetings and staff meetings. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a timely manner.</p> <p>Meetings held prior to October 2018 have been changed to enhance attendance and to allow a focus on key issues. The focus group representation includes the unit manager, acting clinical coordinator, registered nurses and senior healthcare assistants. This focuses on clinical areas such as weight loss, and key operational and staffing issues such as health and safety and quality improvement activities. The focus group meetings are held prior to the staff meeting with a summary of discussion from each area presented at the staff meeting for discussion. All aspects of the quality and risk management programme are included in both the focus group and staff meetings. These meetings also serve as forums to review progress towards goals. Resident meetings are held quarterly and there are opportunities for relatives to have input into the service through the open-door policy of the unit manager and through the annual resident and relative satisfaction survey.</p> <p>The annual satisfaction survey completed in 2018, showed improved satisfaction since the last survey related to activities, housekeeping, laundry, maintenance and food services. The average rating (using a 1 to 5-point Likert scale where 5 is best) is 4.</p> <p>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. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The focus group meetings include a review of falls and actions to improve any areas identified. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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.</p> <p>Fifteen incident forms sampled from December 2018, included appropriate follow-up by a registered nurse and investigation of incidents to identify areas to minimise the risk of recurrence. Monthly analysis of incidents by type has been undertaken by the service and reported to the focus group and staff meetings. Corrective action plans are completed when the number of incidents has exceeded the benchmark with these signed off when strategies and actions have been implemented. Neurological observations are completed as per policy for any resident with a fall involving a head injury or for an unwitnessed fall.</p> <p>Senior management are aware of the requirement to notify relevant authorities in relation to essential</p>

		<p>notifications. Section 31 notifications have been made for relevant issues with the Ministry of Health notified of any pressure injuries or other key issues.</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>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and skills. A copy of practising certificates is kept for staff and external health providers, with all current.</p> <p>Eight staff files were reviewed (the acting clinical coordinator, three registered nurses, two activities coordinators, two healthcare assistants) and included all appropriate documentation. Healthcare assistant staffing levels are stable. There is now a full complement of registered nurses, however most left in the first half of 2018 and six of the eight registered nurses in the service are in the CAP year. These six registered nurses have all had nursing experience for over five years in their country of origin mostly in the emergency departments. Two registered nurses have two or three years of experience in aged care nursing. One is taking on the acting clinical coordinator role while recruitment of a clinical coordinator takes place. A section 31 was sent to the Ministry of Health to inform them of two shifts in February when a registered nurse was not able to be replaced.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. New staff interviewed stated that they had an in-depth orientation programme that included reading of policies and a buddy system that was in place for at least three weeks. Annual appraisals are conducted for all staff with these completed in the past year for all.</p> <p>There was a completed in-service calendar for 2018 and 2019 which exceeded eight hours annually for staff who attended the 2018 training offered. The service has changed to an on-line training programme that has increased attendance to 100% for topics identified by the unit manager as requiring to be completed.</p> <p>Healthcare assistants have completed either the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme.</p> <p>There are a total of 46 staff employed at the service including 34 healthcare assistants; eight registered nurses two activities staff; two reception staff. Laundry, kitchen and household services are outsourced. The unit manager and all registered nurses are interRAI trained.</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>	FA	<p>CHT policy includes staff rationale and skill mix. A review of rosters (February 2019 to current) confirmed that there are sufficient staff rostered and staff are replaced when on leave.</p> <p>Staffing across the dual-purpose beds is designated to specific wings (noting that this is adjusted for acuity and resident numbers). Staff allocated to wing/s on level three on morning and afternoon shifts are as follows: Omaha (14 residents- 8 rest home, 6 hospital) – one healthcare assistant on each shift; Brick and Scandrett (15 residents- 8 rest home, 7 hospital) – two healthcare assistants on the morning and one on the afternoon shift; Kawau and Martins (16 residents - 7 rest home, 9 hospital) – two healthcare assistants on the morning and two on the afternoon shift. Staff allocated to wing/s on level two on morning and afternoon shifts are as follows: Algies and Caulum (14 hospital residents) –two HCAs working a full shift one morning and afternoon plus a five hour floating shift to assist as needed during the morning and evening.</p> <p>Overnight, there are three healthcare assistants and one registered nurse, with one healthcare assistant based in the downstairs level two area at all times.</p> <p>There are three registered nurses in the morning (two full shift and one from 7.00 am to 12.00 pm) and two on the afternoon shift. The unit manager is a registered nurse and they provided support for the registered nurses as well as providing operational management Monday to Friday.</p> <p>There is an on-call process for after hours and staff are aware of how to escalate any concerns. Currently the unit manager is on call, however normally the clinical coordinator also takes part in the roster of on call.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The unit manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical</p>

manner, when their need for services has been identified.		coordinator. The admission agreement form in use aligns with the requirements of the ARC contract.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>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. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored in one of two medication rooms. The medications rooms are secured by a keypad in the main medication room and a key lock downstairs. Medicines are not always appropriately stored in accordance with relevant guidelines. Medication fridge temperatures are checked daily.</p> <p>Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the electronic signing charts or on a pharmacy generated signing chart for short-term residents. Registered nurses and senior healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners document medications on the electronic medication charts correctly and there was evidence of three monthly reviews by the GP. Two residents administer their own medicines and medications are stored in locked draws in the resident's room. Administration records reflect the self-medication. A three-monthly competency assessment completed.</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>	FA	<p>There is a fully functional kitchen and all food is cooked on site by contracted kitchen staff. A food control plan has been verified and expires in April 2020. A food services manual is in place to guide staff. The kitchen staff have completed food safety training. The contracted dietitian, in consultation with the CHT dietitian reviewed the menu in September 2018. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately.</p> <p>A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. Special diets include gluten free and REAP fortified foods. The kitchen manager</p>

		<p>(interviewed) was able to describe alternative meals offered for residents with dislikes. 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 wings.</p> <p>Residents and the family members interviewed were mostly happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. InterRAI assessments have been completed at least six monthly for all residents. Care plans sampled were developed on the basis of these assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plans reviewed, described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate</p>	FA	<p>Registered nurses (RNs) and HCAs, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse] or the wound specialist). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings).</p>

and appropriate services in order to meet their assessed needs and desired outcomes.		<p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents with six wounds, which includes one resident with a complex skin tear. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service (link 1.3.3).</p> <p>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet residents' needs. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</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>	CI	<p>Two activities coordinators are employed to operate the activities programme for all residents. The programme operates five days a week. Each resident has an individual activities assessment on admission, which is incorporated into the interRAI assessment process. An individual activities plan is developed for each resident by the registered nurses in consultation with the activities coordinators. Each resident is free to choose if they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All long-term resident files sampled have a recent activities plan within the care plan and this is appraised at least six monthly when the care plan is evaluated or a further interRAI assessment occurs. The activities programme provides opportunities for residents to share with the community. Recent initiatives have resulted in areas where Amberlea has exceeded the standard. Residents interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. The RN completing the plan signs care plan reviews. Short-term care plans sighted were not always evaluated or documented as resolved or transferred to the long-term care plan. However, if the problem is ongoing, files demonstrated the service responds by initiating changes to the long-term care plan.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. 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 datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 27 May 2019. Amberlea is a two-level building with lift access. There is a maintenance person employed to address the reactive and planned maintenance programme. Essential contractors are available 24 hours. All medical and electrical equipment has been serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The maintenance officer interviewed described the process, should temperatures be above 45 degrees.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas including decks that have seating and shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All rooms on the first floor have toilets and basins. All ground floor rooms have full ensuites. There are adequate numbers of shared communal toilets and showers. Residents interviewed</p>

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		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 of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
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 open plan lounge and dining/kitchenette area in each wing. All communal areas have large windows overlooking sea views. The communal areas are large enough to cater for activities. 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	Contracted cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility. Contracted laundry staff complete all laundry off site. There is a small on-site laundry for personal items such as hip protectors. Residents interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an	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

appropriate and timely response during emergency and security situations.		<p>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.</p> <p>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.</p> <p>The building is secure afterhours with doorbell access at the main entrance and keypad access to the back entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and the description of the infection control programme are available. There is a job description for the infection control (IC) coordinator and clearly defined guidelines. The infection control programme is linked into the quality management programme.</p> <p>The infection control (IC) committee is now part of the focus group meeting which meets monthly. The focus group meeting minutes reviewed included discussion of infection control matters. The IC programme is reviewed annually at head office. The unit manager also reports monthly to the area manager and both attend meetings at head office which include discussion of infection control.</p> <p>The facility has developed links with the general practitioner, local laboratory, the infection control and public health departments at the local district health board.</p> <p>Infection control policies include reference to staff taking leave if they are sick with an infectious disease. Staff interviewed confirmed that they would take leave if they were unwell. Visitors would be informed if there was an outbreak in the community or in the service and asked not to visit.</p>
Standard 3.2: Implementing the	FA	The focus group meeting which includes infection control, includes registered nurses and senior

infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		healthcare assistants as well as the unit manager and clinical coordinator. The facility also has access to an infection control nurse specialist, public health, the general practitioner and expertise within the organisation.
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	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. There is also a 'scope' of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases. The policies are reviewed annually, two yearly and as required in response to changes in legislation or practice. External expertise can be accessed as required, to assist in the development of policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>The service has introduced an external on-line training provider. This includes infection control training and all staff have completed either this on-line training or training from the infection control coordinator in the past year. Confirmation of training was evidenced through attendance records and reports extracted from the on-line training programme. The infection control coordinator also stated that they can work with the staff member as they complete the on-line training to provide support or to provide additional training if required.</p> <p>The orientation package for new staff includes specific training around hand hygiene and standard precautions. Training is also provided at the focus group and staff meetings with staff confirming that this is useful, as it relates to current practice.</p> <p>Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the CHT infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used as required (link 1.3.8). Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the focus group meetings. If there is an emergent issue, it is acted upon in a timely manner.</p> <p>The focus group meeting is attended by registered nurses, senior healthcare assistants, the unit manager and acting clinical coordinator. Staff also receive a summary of the discussion at the staff meetings monthly. Care staff interviewed praised the new focus group meetings as a good process to raise and discuss data, issues and improvements.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</p> <p>The service has documented systems in place to ensure the use of restraint is actively minimised. There is one resident using a lap belt as restraint while in a fall out chair to prevent them slipping off the chair. No residents use enablers. Enabler use is voluntary. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p> <p>Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of the focus group meetings monthly. A registered nurse is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers</p>	FA	<p>The restraint coordinator is a registered nurse. The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions included the restraint coordinator, resident/or family representative (legal guardian) and medical practitioner. Restraint use, and review is part of the focus group meeting.</p>

and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes a comprehensive assessment for residents who require restraint interventions. These are undertaken by suitably qualified and skilled staff (restraint coordinator) in partnership with the family. The restraint coordinator and the legal guardian are involved in the assessment and consent process. The medical practitioner is involved through the three monthly (or as required) medical review. Assessments and approvals for restraint were fully completed. These were sighted in the file reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are followed. There is an assessment form/process that was completed for the restraint used initially and now the interRAI assessment includes reassessment of the use of restraint.</p> <p>The resident record reviewed had a completed assessment that identified risk with interventions to manage the risk detailed in the long-term care plan. Monitoring forms that included regular hourly monitoring (or more frequent) were present in the file reviewed. The assessment included a detailed description of options considered and the rationale for use of the restraint. The long-term care plan detailed interventions and monitoring to prevent injury that could potentially occur from use of the restraint.</p> <p>Consent forms detailing the reason and type of restraint were not completed, however documentation to confirm that the resident and/or family has been involved in care planning which also includes review of any use of restraint is documented.</p> <p>In the resident record reviewed, appropriate documentation has been completed.</p> <p>The service has a restraint and enablers register which had been updated each month. The focus group meeting minutes also form a register of any use of restraint or enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every month as evidenced in the focus group meeting minutes. In the restraint file reviewed, evaluations had been completed with the legal guardian, restraint coordinator and medical practitioner. The three-monthly reviews completed by the general practitioner also indicated review of the use of restraint and any changes to care required. Restraint practices were reviewed on a formal basis every month by the restraint coordinator at the focus group meetings noting that this is attended by unit manager, acting clinical coordinator, registered nurses and senior healthcare assistants. Evaluation timeframes were determined by risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The service actively reviews restraint as part of the internal audit and reporting cycle completed six monthly by the area manager, with input and review of any corrective actions by the unit manager. Reviews were completed six monthly or sooner if a need is identified. Reviews were also completed monthly by the restraint coordinator with these discussed at the focus group meeting. There have not been any adverse outcomes in the last 18 months, as confirmed by the acting clinical coordinator and the unit manager. A review of the focus group meeting minutes for the past six months also confirmed that there had not been any adverse outcomes in the past six months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA</p> <p>Moderate</p>	<p>Medications are stored in two secured medication rooms with the main area located upstairs and a smaller room located downstairs. All eyedrops in use were dated on opening and current. All medications were correctly stored in the main room; however, storage downstairs did not meet regulations.</p>	<p>i) The downstairs medication room was unlocked and the door ajar with no staff in attendance.</p> <p>ii) Unlabelled and opened foil wrapped antibiotics were located on stock shelves.</p> <p>iii) Three expired medications</p>	<p>i) Ensure the medication rooms is secure at all times. ii) Ensure that medications are clearly labelled. iii) Ensure expired medications are disposed of.</p> <p>30 days</p>

			were on the stock shelves.	
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Moderate	Medication is correctly prescribed on an electronic medication administration system for all long-term residents, however the short-term resident pharmacy generated paper medication chart was not fully completed.	The one only paper-based pharmacy generated medication chart did not evidence the signature of a medical officer.	<p>Ensure all medications are charted and signed by a medical officer</p> <p>30 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	Long-term plans are evaluated at least six monthly and files sampled evidenced changes were made as required whenever progress towards meeting goals was different from expected. Short-term cares plans were implemented for weight loss, infections, wound management, and on return from hospital admissions, however not all short-term care plans were evaluated. In files sampled there was evidence of changes to the long-term care plans related to short-term care plans.	Three of eight files samples included short-term care plans in place for between two and five weeks with no evidence of evaluation.	<p>Ensure all short-term care plans are evaluated regularly and either resolved or transferred to the long-term care plan.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Amberlea has made significant improvements to the activities programme as evidenced by an increase in survey satisfaction results. Customer survey results from January 2017 to January 2018 had an average result of between 2.75 and 3.5. A subsequent review of results from January 2018 to January 2019 showed results have increased to between 4 & 4.5.	<p>Amberlea management identified in June that the activities programme had a strong focus on crafts and games in small groups but was not meeting the needs of all residents. The programme was reviewed in consultation with a CHT diversional therapist. A new activities team of two were appointed with the skills to drive the revamped activity programme with a primary focus of reducing social isolation for residents. A number of initiatives including an open day, Christmas shoes boxes and individual activity boxes were implemented.</p> <p>Connection to the community was increased by the Christmas box initiative. The wider community was asked to provide gifts which would fit in a shoe box such as gift cards, toiletries, stationary, games and confectionery. Fifty shoe boxes were packed, and gift wrapped by the residents at Amberlea. The completed shoe boxes were then distributed by Amberlea representatives to the elderly in the community. Thank you letters, confirmed recipient appreciation.</p> <p>The activity box initiative was developed specifically for those residents who either chose not to or were unable to participate in group activities. The</p>

			<p>activities coordinator spent one-on-one time establishing a rapport with these residents and tailored the activities box to each resident's specific interests and abilities. The boxes were delivered to the residents and the activity coordinator evaluated the resident's response weekly. Healthcare assistants were provided with education on the use and benefits of the activity boxes and would engage the residents with their box following daily care. Families became involved and reported the benefits of having a talking point and ability to discuss with the resident's interests.</p> <p>Survey statistics, family feedback and individual weekly evaluations confirm the initiatives have had a positive impact on residents' quality of life.</p>
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End of the report.