# CHT Healthcare Trust - Amberlea Hospital and Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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: 25 March 2021 End date: 25 March 2021

**Proposed changes to current services (if any):** The service is also certified to provide dementia level care. This should be identified in the table above.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 58

# 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

The service cares for up to 72 residents across three service levels (hospital, rest home, and dementia level care). On the day of the audit, there were 58 residents. The unit manager oversees the service with the support of the area manager and clinical coordinator. Residents, relatives, and the GP interviewed spoke very positively about the service provided.

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

The service identified a number of improvements since the last audit including the opening of the dementia unit, the use of activity boxes, and more than 12 months of being restraint free.

The shortfalls identified at the previous partial provisional audit around an activities programme for the dementia unit, furnishing and safety of rooms with equipment is in place in the dementia unit, security of outdoor areas with shade and seating for residents in the dementia unit, and completion of orientation for staff working in the dementia unit have all been met.

This audit identified shortfalls related to temperature of the medication fridge and to review of the unit business plan.

## 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. |

The service has a culture of open disclosure. Families are regularly updated of residents’ condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

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

The service has a unit manager who provides operational management along with the clinical coordinator who provides oversight of the clinical component of service delivery. Registered nurses, health care assistants, and support staff work to deliver services.

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

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

There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a staffing roster developed that meets the needs of residents.

## Continuum of service delivery

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

The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

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

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

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

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

## Safe and appropriate environment

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

The building has a current building warrant of fitness and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place.

## Restraint minimisation and safe practice

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

There are policies to minimise the use of restraint and enablers. Staff have training around managing challenging behaviour. There are no enablers or restraint used in the service.

## Infection prevention and control

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

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 42 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 1.1.13: 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 the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. Managers and care staff interviewed were able to describe the process around reporting complaints.  Managers and staff interviewed included the following: one unit manager, the area manager, clinical coordinator, two registered nurses, five health care assistants from a range of levels of care, the cook, two activities coordinators and a pharmacist.  A complaints’ register is maintained electronically. Verbal and written complaints are documented and include any concerns identified in the resident/relative meetings and satisfaction surveys. There have been five complaints in 2021 to date and 26 in 2020. Three complaints reviewed had a documented investigation and the outcome communicated to the complainant by letter or face-to-face meetings. A full review was documented for each complaint. Timeframes for addressing each complaint were compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) were documented.  There have not been any complaints lodged with the HDC or other external providers since the last audit.  Complaints received and corrective actions are discussed in the quarterly quality meetings. Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the registered nurses (RNs) and management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Five residents interviewed (three in rest home level of care and two in hospital level of care) and six family interviewed (three with family in the dementia unit, one with family in the rest home and two with family in the hospital) stated they were kept informed promptly when their/or residents’ health status changes. They also stated that they were informed in a timely manner when an incident had occurred. All 12 incident forms reviewed confirmed that family were informed of an incident.  There are monthly resident meetings held with family invited to attend. Family newsletters are published quarterly. There are portable phones, skype available on laptops and Wi-Fi to encourage families and residents to maintain communication particularly through Covid 19 lock down.  There is access to interpreters if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Amberlea is part of the CHT Healthcare Trust (CHT) group of facilities. The service currently provides rest home and hospital (geriatric and medical) and dementia level of care for up to 72 residents. On the day of the audit, there were 58 residents in total: 22 rest home level, four in the dementia unit including one using respite care (a 15 bed unit), and 32 hospital level including three residents under an interim care contract. One other hospital resident was under a POAC (primary option acute care) contract. All others are under the Age-Related Residential Care contract. All rooms in the rest home and hospital area are dual-purpose.  CHT has a documented philosophy of care, mission statement and overall business/strategic plan with goals and key performance indicators however there is no evidence that these are reviewed. The philosophy is focussed on providing great care of older people and this will continue to be relevant with the addition of the dementia unit. The unit manager’s performance plan identifies business goals for the current year. These goals are not always regularly reviewed and signed off when achieved. There is a transition plan in place to manage all aspects related to occupancy of the dementia unit.  The unit manager is a registered nurse who maintains an annual practicing certificate. They have over 15 years’ experience in aged care and have been in the role as unit manager for two and a half years. They are supported by the clinical coordinator who has six months experience in aged care as a registered nurse and has been in the role for six months. The unit manager reports to an area manager on a regular basis (minimum of monthly). All managers and the clinical coordinator have completed at least eight hours of professional development along with management training. |
| 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. | FA | The unit manager is responsible for providing oversight of the quality programme and was able to describe the value and detail of the programme. The quality and risk management programme is documented and designed to monitor contractual and standards compliance.  A document control system is in place with all quality documents reviewed on an annual basis by area managers. New policies or changes to policy are sent to the unit and communicated to staff, as evidenced in meeting minutes.  Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints, and internal audit outcomes. Staff interviewed confirmed they are kept informed on quality data, trends and correctives actions at the monthly staff meetings and the quality meetings which restarted in 2021. Meetings were held in 2020 when possible (noting that Covid 19 pandemic delayed some of these being held). The quality meetings include health and safety, infection control and review of restraint. There are weekly meetings for staff in the dementia unit as the unit is new. This supports cohesion of service delivery. There are also monthly registered nurse meetings facilitated by the clinical coordinator, and staff household meetings.  The area manger completes six monthly internal audits against core standards, restraint, and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off when completed.  Annual resident/relative surveys are completed, and the results fed back to participants through newsletters and resident/relative meetings. The 2020 results showed a high level of satisfaction over the rest home and hospital areas (noting that the dementia unit had not been operationalised).  The service has a health and safety programme in place. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety is included in the combined quality and staff meetings. The unit manager is the health and safety representative and is able to describe their role. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling and there is ongoing online training for all staff annually. Hazard identification forms are implemented. There is a current hazard register in place. All contractors complete an induction to the facility.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. |
| 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. | FA | Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. Twelve resident related incident reports for the last quarter 2020 and 2021 were reviewed. All reports evidenced that family had been notified and appropriate clinical care was provided following an incident. Eight of the 12 incidents related to residents who had had an un-witnessed fall or had hit their head. All neurological observations were completed for all un-witnessed falls or where a resident sustained a head injury. Documentation including care plan interventions for prevention of incidents, was fully completed.  There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality and clinical meetings, and at handovers as observed on the day of audit. Staff interviewed confirmed incident and accident data was discussed and information is made available.  Discussions with management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have not been any Section 31 notifications since the previous audit. |
| 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. | FA | There are human resources policies to support recruitment practices. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications and experience.  The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (one clinical coordinator, two RNs, an activities coordinator, and one HCA). All files contained relevant employment documentation including reference checks and orientations. Annual staff appraisals were evident in all staff files reviewed.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2020 has been completed and implemented. In addition to the scheduled education programme staff have access to online education. The unit manager, clinical coordinator and registered nurses can attend external training, including sessions provided by the local district health board (DHB).  There are seven registered nurses including the clinical coordinator who have completed interRAI training.  Existing staff are rostered to staff the dementia unit. An orientation to the dementia unit has been rolled out to all staff who work in the dementia unit.  All of the registered nurses and the clinical coordinator have worked in aged care. One registered nurse has worked in psycho-geriatric care for two years prior to working at CHT Amberlea and has experience in aged care nursing. They take a lead in the dementia unit as a registered nurse.  There are 33 HCAs. Staff have or are completing CareerForce training or equivalent. Currently there are two staff who have completed level two training (13 in training); nine staff have completed level three training (1 in training); and two have completed level four training (9 in training). There are five HCAs who work currently in the dementia unit and all are in training to complete the NZQA dementia training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The unit manager and clinical coordinator are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns. Staff stated they feel supported by the management team who respond quickly to afterhours calls.  Staffing across the dual-purpose beds is designated to specific wings (noting that this is adjusted for acuity and resident numbers).  There are four wings upstairs with a total of 37 beds and 36 occupied. Wings are called Brick Bay (eight beds with five rest home and three hospital); Scandrett (seven beds with two rest home and five hospital); Martin (13 beds with seven rest home and six hospital including the resident under a POAC contract); Kawau (nine residents - three rest home, five hospital).  There are two wings downstairs with a total of 20 beds – 18 occupied. Wings are Algies (13 beds with three rest home and nine hospital); and Tawhanui (seven beds with two rest home residents and four hospital residents).  The dementia unit is called Omaha and has 15 beds with an occupancy of four residents.  There are six HCAs on full shifts in the morning and two on short shifts (three on long shifts are placed upstairs, two on long shifts are placed downstairs and one in the dementia unit). The two short shifts work from 7AM-12PM and 9AM to 2PM and both work downstairs.  There are five HCAs on full shifts in the afternoon and one on a short shift from 4PM-9PM (one in the dementia unit, two HCAs upstairs and two downstairs with the short shift working between up and downstairs.  Overnight, there are three healthcare assistants and one registered nurse, with one healthcare assistant based in the downstairs level at all times.  There are two registered nurses in the morning as well as the clinical coordinator and two on the afternoon shift. The unit manager is a registered nurse and provides support for the registered nurses as well as providing operational management Monday to Friday.  There are 49 staff in total including the unit manager, clinical coordinator, 33 healthcare assistants, seven registered nurses, three activity coordinators, two reception staff, one maintenance and one gardener. Laundry, cleaning, and food services are contracted to external providers. |
| 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 Low | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on-site.  All clinical staff (RNs, med-comp HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and a caregiver interviewed could describe their role regarding medication administration.  The service currently uses robotics for regular medication and ‘as required’ medications. All medications are checked on delivery against the medication chart (medimap) and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, however not all medication fridge temperatures were within acceptable ranges. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.  Staff sign for the administration of medications electronically. Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. ‘As required’ medications had indications for use charted. |
| 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. | FA | Food services are outsourced to a contractor. The meals at CHT Amberlea are all prepared and cooked on site. The kitchen was observed to be clean and well-organised, and a current approved food control plan was in evidence, expiring 7 April 2022. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss.  The chef manager (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.  Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the servery. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses.  The residents interviewed were satisfied with the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative’s health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents’ mobility and transfer needs as required.  Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both a paper based wound log and the Vcare system. There were 15 ongoing wounds including four abrasions, seven skin tears (three DHB acquired), two lesions, one chronic ulcer and one post-surgical wound. The service has no current pressure injuries. The service has access to a wound nurse specialist as required for input and advice as required and this was in evidence with the chronic ulcer.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.  Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.  Care plans have been updated as residents’ needs changed. |
| 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 five activity coordinators who provide a seven-day programme across all care levels. A company diversional therapist (DT) oversees the activity programmes. The activity coordinators attend CHT workshops and on-site in-services. The two activities coordinators interviewed on day of audit were working towards their DT qualifications. All hold current first aid certificates.  The programme is planned monthly and includes CHT minimum requirements for the activities programme, including themed cultural events. Activities programmes are displayed on notice boards around the facility and a monthly calendar is delivered to each individual resident. Activities are documented for each of the care areas, including dementia care. There is also a separate activities programme for the dementia unit. The previous audit shortfall around documentation of an activities programme for the dementia unit has been addressed.  Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One-on-one time is spent with residents who are unable to actively participate in the activities.  A variety of individual and small group activities were observed occurring in the care units at various times throughout the day of audit. Residents also participated in a community van trip on the day of audit. Entertainment and outings are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed.  An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment and outings. Resident meetings are held monthly and family are invited to attend. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents interviewed spoke positively about the activity programme provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan.  Five resident files were reviewed (three hospital [including one interim care and one POAC resident], one rest home level and one dementia level (respite) resident). As three of the five files were short term residents, the sample was increased by three to include a long-term resident from each care level. Five long-term care files sampled of permanent residents contained written evaluations completed six-monthly. The other three files were of short-term residents for whom that evaluation was not applicable. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes. |
| 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 holds a building warrant of fitness which expires 27 May 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.  Electrical equipment has been tested and tagged, the next checks being due November 2021. Items of medical equipment are calibrated annually and are next due to be checked October 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range.  Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, decked areas and gardens are well maintained. All outdoor areas have attractive features and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.  The dementia unit has a secure courtyard/deck which is accessible from the dementia unit. This outdoor area now has shade, seating and an environment that is suitable for residents in the dementia unit. The shortfall identified at the partial provisional audit has been met.  The dementia unit is now occupied. The rooms in the dementia unit are all furnished, and fittings/chattels installed. The shortfall identified at the partial provisional audit has been met. The floor to ceiling clear glass window in the lounge/dining room in the rest home had a bar across the middle of the glass above waist height identifying it as a window. The managers state that it has safety glass. The room is now furnished with a lounge suite in front of the lower portion of the window and this serves as a barrier to residents walking into the glass. The shortfall identified at the partial provisional audit has been met. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Staff who work in the dementia unit received an orientation to the unit prior to occupancy that included emergencies and security. The shortfall regarding this identified at the partial provisional audit around training for staff in the dementia unit prior to occupancy has been addressed.  Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque.  There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. All shifts have a current first aider on duty.  Residents’ rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert.  Security policies and procedures are documented and implemented by staff. The buildings are secure at night. There is security lighting. |
| 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 | The surveillance programme is organised and promoted centrally from CHT head office. Effective monitoring is the responsibility of the infection control coordinator (RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the RN meeting and monthly staff meetings.  The overall effectiveness of the surveillance programme is evaluated annually by the CHT infection control committee. All meetings held at CHT Amberlea include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and are analysed at site level using Vcare.  There have been no outbreaks since the last audit.  The service has prepared at least two weeks of personal protective equipment including gowns, gloves, and masks. Staff have completed training on use of PPE, cough etiquette and hand hygiene. Residents are provided with training and oversight of standard precautions with this occurring during resident meetings and as required.  An organisational Covid-19 strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE, these details being passed on to families via email, telephone and in writing. During Covid lockdown the service implemented weekly staff briefings which allowed for updates, education and discussion. All visitors are required to provide contact tracing information |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. Staff in the dementia unit have had training around restraint minimisation, safe practice and management of challenging behaviours. The clinical coordinator and unit manager stated that enablers or restraint would not be used in the dementia unit. The dementia unit is secure.  All staff have completed training on challenging behaviour in 2020 and they have also completed this as part of the online training completed as one of the modules in the past seven weeks. |

# 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 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | A unit business plan identified goals and key performance indicators (KPIs). At other CHT facilities, the managers performance plan was described by the area manager as being the document that included review of the goals and progress against KPIs. A manager’s performance plan was not sighted specifically for this site and there was little evidence of review of the goals and KPIs. | The goals and KPIs documented in the unit business plan are not reviewed at regular intervals. | Review the goals and KPIs in the unit business plan at regular intervals.  180 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 Low | There is a fridge to store medications in. Fridge temperatures are taken daily, and most temperatures recorded show the fridge to be in normal range as per policy. | Seven of twenty-five daily medication fridge temperature recordings were below the acceptable range with no documented corrective action. | Ensure all medication is stored safely within the required temperature range.  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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End of the report.