# 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 Ngā paerewa Health and disability services standard (NZS8134:2021).

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 Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora 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); Dementia care

**Dates of audit:** Start date: 30 May 2024 End date: 31 May 2024

**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:** 71

# 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 sections contained within the Ngā paerewa Health and disability services standard:

* ō tātou motika **│** our rights
* hunga mahi me te hanganga │ workforce and structure
* ngā huarahi ki te oranga │ pathways to wellbeing
* te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
* te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
* here taratahi │ restraint and seclusion.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded |
|  | No short falls | Subsections 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 subsections applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some subsections 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 subsections applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Amberlea Hospital and Rest Home (CHT Amberlea) is owned and operated by CHT Healthcare Trust and cares for up to 72 residents requiring hospital (medical and geriatric), rest home and dementia level of care. On the day of the audit there were 71 residents.

This surveillance audit was conducted against the Ngā Paerewa Health and Disability Services Standard 2021 and the contracts with Health New Zealand Te Whatu Ora – Waitematā. The audit process included the review of policies and procedures; the review of residents and staff files; observations; and interviews with residents, family/whānau, management, staff, and a general practitioner.

There have not been any changes in management since the last audit. The unit manager is appropriately qualified and experienced in healthcare management. The unit manager is supported by a clinical coordinator, who has been in the role for more than a year. They are both supported by the CHT area manager.

There are quality systems and processes being implemented. Feedback from residents and families/whānau was positive about the care and the services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

This surveillance audit identified that there are corrective actions required relating to the implementation of the quality and risk management programme, and staff training.

## Ō tātou motika │ Our rights

|  |  |  |
| --- | --- | --- |
| Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people’s rights, facilitates informed choice, minimises harm,  and upholds cultural and individual values and beliefs. |  | Subsections applicable to this service fully attained. |

CHT Amberlea provides an environment that supports resident rights and safe care. Staff demonstrated an understanding of residents' rights and obligations. There is a Māori health plan and a Pacific health plan in place. The service aims to provide high-quality and effective services and care for residents.

Residents receive services in a manner that considers their dignity, privacy, and independence. CHT Amberlea provides services and support to people in a way that is inclusive and respects their identity and their experiences. The service listens and respects the voices of the residents and effectively communicates with them about their choices. Care plans accommodate the choices of residents and/or their family/whānau. There is evidence that residents and family/whānau are kept informed. The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well-documented.

## Hunga mahi me te hanganga │ Workforce and structure

|  |  |  |
| --- | --- | --- |
| Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce. |  | Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The business plan includes a mission statement and operational objectives. The service has a documented quality and risk management systems that takes a risk-based approach. Quality data is analysed to identify and manage trends. Quality improvement projects are implemented. Internal audits and collation of data were documented as taking place, with corrective actions as indicated. The service complies with statutory and regulatory reporting obligations.

A health and safety system is in place. Health and safety is monitored by the health and safety committee. Staff incidents, hazards and risk information is collated at unit level, reported to the area manager and a consolidated report and analysis of all CHT facilities are then provided to the Board each month.

There is a staffing and rostering policy documented. Human resources are managed in accordance with good employment practice. A role specific orientation programme and regular staff education and training are in place. Staff are suitably skilled and experienced. Competencies are defined and monitored, and staff performance is reviewed.

## Ngā huarahi ki te oranga │ Pathways to wellbeing

|  |  |  |
| --- | --- | --- |
| Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs. |  | Subsections applicable to this service fully attained. |

The unit manager and clinical coordinator efficiently manage entry processes. The registered nurses and the general practitioners assess residents on admission. The service works in partnership with the residents, their family/whānau and enduring power of attorneys to assess, plan and evaluate care. Care interventions were individualised and appropriate for all residents. Residents are reviewed regularly and referred to specialist services and to other health services as required. Transfers and discharges are managed in a safe manner.

There is a safe medication management system in place. Medicines are safely stored. The organisation uses an electronic system for prescribing and administration of medications. Medication reviews were completed in timely manner.

The food service meets the nutritional needs of the residents, with special needs catered for. Food is safely managed. The menu was reviewed by a qualified dietitian. Nutritional snacks are available over a 24-hour period. Residents verified satisfaction with meals.

Transfers between services are coordinated in a manner than provides continuity of care.

## Te aro ki te tangata me te taiao haumaru │ Person-centred and safe environment

|  |  |  |
| --- | --- | --- |
| Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities. |  | Subsections applicable to this service fully attained. |

The building warrant of fitness was completed. Electrical equipment has been tested and tagged. All medical equipment has been serviced and calibrated.

## Te kaupare pokenga me te kaitiakitanga patu huakita │Infection prevention and antimicrobial stewardship

|  |  |  |
| --- | --- | --- |
| Includes five subsections that support an outcome where Health and disability service providers’ infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance. |  | Subsections applicable to this service fully attained. |

A suite of infection prevention and control policies and procedures are documented and reviewed annually. The infection control resource nurse is a registered nurse. The infection control resource nurse has access to a range of resources. Education is provided to staff at induction to the service and is included in the education planner. Internal audits are completed, with corrective actions completed where required.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are collected and analysed for trends and the information used to identify opportunities for improvements. Internal benchmarking within the organisation occurs. Staff are informed about infection control practices through meetings, and education sessions. Covid-19 response plans are in place and the service has access to personal protective equipment supplies. There were six Covid- 19 events previously reported. There was a Covid-19 outbreak at the time of the audit and this was being well documented.

## Here taratahi │ Restraint and seclusion

|  |  |  |
| --- | --- | --- |
| Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people’s dignity and mana are maintained. |  | Subsections applicable to this service fully attained. |

There are no restraints currently in use at CHT Amberlea. The governance body are committed to eliminating the use of restraint. Restraint minimisation is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and would only use an approved restraint as the last resort.

## Summary of attainment

The following table summarises the number of subsections 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)** |
| **Subsection** | 0 | 16 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 45 | 0 | 2 | 1 | 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)** |
| **Subsection** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, 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).

|  |  |  |
| --- | --- | --- |
| **Subsection with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Subsection 1.1: Pae ora healthy futures  Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi. | FA | A Māori health plan is documented for the service that acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. The service currently has residents who identify as Māori. Amberlea Hospital and Rest Home (CHT Amberlea) is committed to respecting the self-determination, cultural values, and beliefs of Māori residents and family/whānau and evidence is documented in the resident care plan and evidenced in practice. CHT Amberlea has a relationship with Te Hana marae and links are established with the other kaumātua. Mana motuhake is recognised through the care planning process. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa  The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes. | FA | The Pacific Health and Wellbeing Plan 2020-2025 is the basis of the CHT Pacific health plan that is in place and being implemented. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships, valuing families, and providing high quality healthcare.  On admission all residents state their ethnicity. There were no residents identifying as Pasifika at the time of the audit. The unit manager confirmed that the residents’ family/whānau are encouraged to be involved in all aspects of care, particularly in nursing and medical decisions, satisfaction of the service and recognition of cultural needs.  CHT Amberlea partners with Pacific employees to ensure connectivity within the region to increase knowledge, awareness and understanding of the needs of Pacific people. |
| Subsection 1.3: My rights during service delivery  The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | FA | Details relating to the Code are included in the information that is provided to new residents and their family/whānau. The unit manager, clinical coordinator or registered nurses discuss aspects of the Code with residents and their family/whānau on admission. The Code is displayed in multiple locations in English and te reo Māori.  Seven residents (three rest home and four hospital) and nine family/whānau (two rest home, four hospital and three dementia) interviewed reported that the service is upholding the residents’ rights. Interactions observed between staff and residents during the audit were respectful.  Three managers (unit manager, clinical coordinator and area manager) and ten staff interviewed (six healthcare assistants, two registered nurses, maintenance officer and kitchen manager) all demonstrated a good understanding and provided examples of how the Code is upheld. |
| Subsection 1.5: I am protected from abuse  The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse. | FA | An abuse and neglect policy is being implemented. CHT Amberlea policies prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. CHT as an organisation is inclusive of ethnicities, and cultural days are held to celebrate diversity. A staff code of conduct is discussed during the new employee’s induction to the service, with evidence of staff signing the code of conduct policy. This code of conduct policy addresses the elimination of discrimination, harassment, and bullying. CHT Māori Health Strategy includes strategies to abolishing institutional racism.  Staff attend education on how to identify abuse and neglect; however, the training records reviewed evidence that 71 percent of staff are overdue to complete the topic (link 2.3.4). Staff are educated on how to value the older person, showing them respect and dignity. All residents and family/whānau interviewed confirmed that the staff are very caring, supportive, and respectful.  Police checks are completed as part of the employment process. The service implements a process to manage residents’ comfort funds. Professional boundaries are defined in job descriptions. Interviews with registered nurses (RNs) and healthcare assistants (HCAs) confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. |
| Subsection 1.7: I am informed and able to make choices  The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control. | FA | There are policies around informed consent. Five resident files reviewed included signed general informed consent forms. Consent forms for Covid-19 and flu vaccinations were also on file where appropriate. Residents and family/whānau interviewed could describe what informed consent was and their rights around choice.  Admission agreements had been signed and sighted for all the files seen. Copies of enduring power of attorneys (EPOAs) were on resident files where applicable. Where an EPOA has been activated, an activation letter was on file. |
| Subsection 1.8: I have the right to complain  The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement. | FA | The complaints management procedure is provided to residents and family/whānau on entry to the service. The unit manager maintains a record of all complaints, both verbal and written, by using a complaint register. This register is held electronically. Documentation, including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commission (HDC).  There have been thirteen complaints recorded for 2022/2023 since the last audit, and eleven complaints for 2024 year to date. There was one complaint in August 2023 that was investigated in collaboration with New Zealand Health Te Whatu Ora- Waitematā. This complaint has been resolved and closed off. Quality improvements and corrective actions sighted.  Five complaints logged were reviewed and include an investigation, follow up, and replies to the satisfaction of the complainant. Complaints (and any subsequent corrective actions) are discussed in the quarterly quality and health and safety and registered nurse meetings; however, general staff meetings have not occurred as scheduled and not all staff are informed (link 2.2.2). Higher risk complaints are managed with the support of the area manager.  Discussions with residents and family/whānau confirmed they are provided with information on complaints and complaint forms are available at the entrance to the facility, nurses’ station and on request. Residents have a variety of avenues they can choose from to make a complaint or express a concern. Resident meetings are held bimonthly and create a platform where concerns can be raised. During interviews with family/whānau, they confirmed the unit manager is available to listen to concerns and acts promptly on issues raised. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. Information about support resources for Māori is available to staff to assist Māori in the complaints process. Māori residents are supported to ensure an equitable complaints process. The unit manager acknowledged the understanding that for Māori there is a preference for face-to-face communication. |
| Subsection 2.1: Governance  The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. | FA | CHT Amberlea is located in Algies Bay and is part of CHT Healthcare Trust (CHT). CHT oversee nineteen aged care facilities on the North Island. CHT Amberlea provides care for up to 72 residents at hospital level (medical and geriatric), rest home and dementia level of care. Fifty-seven beds are certified as dual-purpose beds (including one double room), and there are fifteen beds in the dementia unit (including one double room). The double room in the dual purpose unit was occupied by a married couple.  On day one of the audit, there were 71 residents: 36 rest home, including one resident on a younger person with a disability (YPD) contract, and one resident on respite care; 20 hospital level; and 14 in the dementia unit. The remaining residents were under the age-related residential care (ARRC) agreement.  CHT has an overarching strategy map with clear business goals to support organisational values. One of CHT’s key business goals is to provide equal access to aged care services. They aim to achieve this by providing affordable care and by enhancing physical and mental wellbeing of their residents. CHT premium rates and room sizes are in line with those principles, supporting their goal.  The business plan (2023-2024) includes a mission statement and operational objectives, with site specific goals related to budgeted occupancy; complaints management; resident satisfaction; availability of standard rooms; customer engagement; and staff satisfaction. The unit manager reports on these areas monthly to the area manager.  The governance body of CHT Healthcare Trust consists of seven trustees. Each of the trustees contributes their own areas of expertise to the Board, including legal; accounting; medical; human resources; marketing; and business management. The Chairperson of the Board is also an experienced director and chairs other organisational Boards. The area manager interviewed explained the strategic plan, its reflection of collaboration with Māori, which aligns with Manatū Hauora Ministry of Health strategies and addresses barriers to equitable service delivery.  The Quality, Health & Safety Committee (QHSC), which is a sub-committee of the Board and reports to the Board, includes ‘Monitor CHT’s compliance with its policies and procedures on quality health and safety and relevant legislation and contractual requirements,’ as a part of its responsibilities.  With the introduction of the Ngā Paerewa Health and Disability Services Standard, the Senior Management Group has developed an action plan to ensure the successful implementation of the Standard. The governance body are overseeing this via a standing agenda item on the QHSC.  CHT’s Māori Health Plan incorporates the principles of Te Tiriti o Waitangi, including partnership in recognising all cultures as partners and valuing each culture for the contributions they bring. This is a governance document. Cultural advisors at the governance level ensure Māori have meaningful representation in order to have substantive input into organisational operational policies. CHT Amberlea have their own set of milestones developed to set objectives for each key area of service delivery, including achieving equity for Māori and people with disabilities. The milestones are regularly reviewed by the unit manager and area manager.  The quality programme includes a quality programme policy, and quality goals (including site specific business goals) that are reviewed at the quarterly quality and health and safety meetings. The area managers provide the clinical oversight for the care facilities and provide a detailed analysis of clinical data to the Board, prior to every Board meeting. Discussions are held at the Board meeting around the issues raised and any corrective actions taken. The clinical data is compared both internally as well as externally, against the national clinical benchmarking data.  The unit manager (registered nurse) has been in the role for 18 months. The area manager, clinical coordinator, and registered nurses support the unit manager.  The manager has completed more than eight hours of training related to managing an aged care facility and includes privacy related training; CHT specific business related training; infection control; cultural, including Te Tiriti O Waitangi; and restraint training. |
| Subsection 2.2: Quality and risk  The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers. | PA Moderate | CHT Amberlea has an established quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of key performance indicator data. Key performance indicator data (clinical indicator data including, falls, skin tears, infections, episodes of behaviours that challenge, infections), restraint, complaints, and results from satisfaction surveys are collected, analysed at unit level, and benchmarked within the organisation.  Internal audits are completed six-monthly by the area manager. Corrective actions are documented to address service improvements, with evidence of progress and sign off when achieved. Quality improvement projects have been developed and being implemented to include improvement related to food services, activities provided, and staff education. Progress has been documented.  Quality, health and safety, registered nurse and staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints; compliments; staffing; and education. There is a meeting schedule. Meeting minutes reviewed evidence quality data is shared in the quarterly quality, health and safety meetings and registered nurse meetings; however, the scheduled monthly staff meetings have not occurred as planned. Meeting minutes and graphs are not displayed on noticeboards for staff to review.  Resident and family/whānau satisfaction surveys are completed monthly, with a selection invited each month (on the yearly anniversary of their admission), with the aim of covering all residents and families/whānau in a calendar year. Surveys completed in 2023 and 2024 reflect high levels of resident/family satisfaction related to care, friendliness, personal attention, housekeeping and general maintenance. Corrective measures are being implemented for food services that have been scoring low in the surveys. The area manager stated a range of improvements had already been made and implemented. Satisfaction related to the activities programme showed slight improvement from 2023 to 2024, with ongoing improvements being implemented.  There are procedures to guide staff in managing clinical and non-clinical emergencies. A document control system is in place. Policies are regularly reviewed.  A health and safety system is being implemented, with the service having trained health and safety representatives. Hazard identification forms and an up-to-date hazard register were sighted. The health and safety team meets quarterly. Hazards identified were not always eliminated in a timely manner. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. Health and safety training begins at orientation and continues annually.  Ten accident/incident forms reviewed for April/May (unwitnessed falls, skin tears, behaviour, and bruise) indicated that the electronic forms are completed in full and are signed off by an RN and the unit manager/clinical coordinator. Incident and accident data is collated monthly and analysed by both the unit manager and the area manager. These were limited evidence that general staff are engaged in discussions.  Discussions with the unit manager evidenced their awareness of the requirement to notify relevant authorities in relation to essential notifications. Several Section 31’s related to RN staffing (December 2022 to July 2023) had been submitted since the previous audit. There has been one Covid-19 outbreak (May 2024- present) since last audit. The outbreak is currently ongoing, with the last residents being cleared to come out of isolation. Outbreaks have been appropriately notified, managed and staff continue to be debriefed. |
| Subsection 2.3: Service management  The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services. | PA Low | There is a staffing policy that describes rostering requirements, determines staffing levels and skill mixes to provide culturally safe care, 24 hours a day, seven days a week. The roster provides appropriate coverage for the effective delivery of care and support. The facility adjusts staffing levels to meet the changing needs of residents. The registered nurses, activity coordinator and a selection of healthcare assistants have completed first aid training. There is a first aid trained staff member on duty 24/7.  The clinical coordinator provides clinical oversight and the unit manager is responsible for the implementation of the quality and risk management system and day-to day operations of CHT Amberlea. Both the clinical coordinator and unit manager work full time Monday to Fridays and provide on-call clinical support after hours. The area manager provides support in the absence of the unit manager. Rosters from the past three weeks showed that any short absences are backfilled with CHT staff or agency staff when required. The unit manager confirmed that CHT Amberlea had above 50 percent turnover in the past 18 months. There are no current staff vacancies. There is a registered nurse on 24/7 with sufficient number of healthcare assistants. Medication competent healthcare assistants provide medication support on each shift.  Staff and residents are informed when there are changes to staffing levels, evidenced in interviews. Residents interviewed confirmed their care requirements are attended to in a timely manner. Interviews with staff confirmed that their workload is manageable.  There is an annual education and training schedule being implemented. The education and training schedule lists compulsory training which is provided through an online platform or face to face training sessions. The cultural awareness online training module includes the provision of safe cultural care, cultural models of care, Māori world view and the Treaty of Waitangi; however, not all staff have completed the cultural awareness training and abuse and neglect training.  External training opportunities for care staff includes training through Health New Zealand- Waitemata, hospice and the organisation’s online training portal, which can be accessed on personal devices.  The service supports and encourages healthcare assistants to obtain a New Zealand Qualification Authority (NZQA) qualification. Forty-two healthcare assistants are employed. Twenty healthcare assistants have achieved a level 4 NZQA qualification; five HCAs have achieved level 3; and nine HCAs have achieved level 2. The CHT Amberlea orientation programme includes core competencies and compulsory knowledge/topics are addressed.  Twenty-three staff are currently rotated through the dementia unit. Ten HCAs have completed the level four limited care pathway (LCP) dementia unit standards, and nine healthcare assistants are in progress (all have worked in the unit for less than 18 months). However, four has been working in the dementia unit for longer than 18 months and are not yet enrolled.  All staff are required to complete competency assessments as part of their orientation. All HCAs are required to complete annual competencies for restraint; handwashing; correct use of personal protective equipment; cultural safety; and moving and handling. A record of completion is maintained on an electronic register. Additional registered nurse specific competencies include syringe driver and interRAI assessment competency. Eight registered nurses (including the clinical coordinator) are employed, with six of them interRAI trained. All registered nurses are encouraged to also attend external training, webinars, and zoom training where available. |
| Subsection 2.4: Health care and support workers  The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one registered nurse, two healthcare assistants, one clinical coordinator and one activity coordinator) evidenced implementation of the recruitment process, employment contracts, police checking, and completed orientation.  There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, and functions to be achieved for each position.  A register of practising certificates is maintained for all health professionals (eg, RNs, GPs, pharmacy, physiotherapy, and dietitian). The appraisal policy is implemented. All staff who have been employed for over one year have an annual appraisal completed. |
| Subsection 3.2: My pathway to wellbeing  The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing. | FA | Five residents’ files were reviewed including one hospital level of care, three rest home level (including a resident on a YPD contract and a resident on respite), and one dementia level of care. The registered nurses (RNs) are responsible for completing the admission assessments, care planning and care plan evaluation. The initial nursing assessments and initial care plans sampled were developed within 24 hours of an admission, in consultation with the residents, enduring power of attorney (EPOA) and family/whānau where appropriate, with resident’s consent. The lifestyle questionnaire used include consideration of residents’ lived experiences, cultural needs, values, and beliefs. Initial interRAI assessments (including YPD) and long-term care plans were completed within three weeks of an admission.  The Māori health care plan utilised when required includes healing methodologies, such as karakia, rongoā and spiritual assistance. The Māori health care plan supports kaupapa Māori perspectives to permeate the care planning process, and support residents, and family/whānau as applicable to identify pae ora outcomes in their care and wellbeing. Residents confirmed that they can practice their culture as desired.  A range of clinical assessments, referral information, observation and the pre admission assessments served as a basis for care planning. Residents, family/whānau and EPOAs confirmed they were involved in the assessment and care planning processes. The long-term care plans sampled identified residents’ strengths, goals, and aspirations. Where appropriate, early warning signs and risks that may affect a resident’s wellbeing were documented. Management of specific medical conditions was well documented, with evidence of systematic monitoring and regular evaluation of responses to planned care. Behaviour management plans were completed for residents in the dementia unit and where applicable for other residents. Triggers were identified and strategies to manage these were documented. Behaviours that challenge were monitored and recorded on the behaviour monitoring charts.  There were nine active wounds at the time of the audit, including skin tears. There were no pressure injuries. Wound management plans were implemented with regular evaluation completed. Referrals to a wound management specialist and a dietitian were completed, where required. The RN confirmed that there are always adequate wound management supplies in stock.  Service integration with other health providers, including medical and allied health professionals, was evident in residents’ records reviewed. Changes in residents’ health were escalated to the general practitioners (GPs) and referral to specialist services were completed, where required. Evidence of this was available in the residents’ files sampled. Referrals sent to specialist services included referrals to the mental health services for older adults, eye specialist, wound care nurse specialist, and radiology department. The GP interviewed stated that there was good communication with the service and that they were informed of concerns in a timely manner. The GP confirmed that medical orders were followed, and care was implemented promptly. Residents were transferred to other health care providers when required.  Medical assessments were completed by the GPs within two to five working days of an admission. Routine medical reviews were completed monthly and three-monthly. More frequent reviews were completed if required as determined by the resident’s needs. Medical records were evident in sampled records. There is a contracted podiatrist who visits the service six-weekly, and a contracted physiotherapist who completes assessments of residents and manual handling training for staff.  Residents’ care was evaluated on each shift and reported in the progress notes by the HCAs. Any resident’s health changes were reported to the RNs and the clinical coordinator, as confirmed in the records sampled and in interviews with care staff. The long-term care plans were reviewed at least six-monthly following six-monthly interRAI reassessments. All the files reviewed had current interRAI assessments. Short-term care plans were completed for acute conditions. Short-term care plans were reviewed regularly as clinically indicated and signed off when the conditions resolved. The evaluations included the residents’ degree of progress towards their agreed goals and aspirations, as well as family/whānau goals and aspirations. Where progress was different from expected, changes to the care plan were completed. Where there was a significant change in the resident’s condition, a referral was made to the needs assessment service coordination (NASC) team for reassessment for level of care. Progress notes are written daily by HCAs and RNs.  Residents’ records, observations, and interviews verified that care provided to residents was consistent with their assessed needs, goals, and aspirations.  A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents’ needs. Residents and family/whānau confirmed their involvement in evaluation of progress and any resulting changes.  Monthly observations, such as weight and blood pressure, were completed and are up to date. Neurological observations are recorded following un-witnessed falls as per policy. A range of electronic monitoring charts are available for the care staff to utilise. These include (but are not limited to) monthly blood pressure and weight monitoring, bowel records, behaviour monitoring and repositioning records. Staff receive handover at the beginning of their shift. |
| Subsection 3.4: My medication  The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and in line with current legislative requirements. A safe system for medicine management was in use. A registered nurse was observed administering medications safely and correctly. The system described medication prescribing, dispensing, administration, review, and reconciliation. Administration records were maintained. Medicine was supplied to the facility from a contracted pharmacy.  A total of ten medicine charts were reviewed. The prescribing practices included the prescriber’s name and date recorded on the commencement and discontinuation of medicines and all requirements for ‘as required’ (PRN) medicines. Medicine allergies and sensitivities were documented on the resident’s chart where applicable. The three-monthly medication reviews were consistently recorded on the medicine charts sampled.  The service uses pre-packaged medication rolls. The medication and associated documentation were stored safely with restricted access. Medication reconciliation was conducted by the RNs when regular medicine packs were received from the pharmacy and when a resident was transferred back to the service. This was verified in medication records sampled. Medicine sampled for review were within current use by dates. Clinical pharmacist input is provided six-monthly and on request. Unwanted medicine was returned to the pharmacy in a timely manner. The records of temperatures for the medicine fridges and the medication rooms sampled were within the recommended range. Opened eyedrops were dated. There were no standing orders in use.  There were no residents who were self-administering medicine on the days of the audit. Appropriate processes were in place to ensure this was managed in a safe manner, when required. There is an implemented process for comprehensive analysis of medication errors and corrective actions implemented as required. Medication audits were completed, with corrective action plans implemented as required. |
| Subsection 3.5: Nutrition to support wellbeing  The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people’s nutrition and hydration needs are met to promote and maintain their health and wellbeing. | FA | Residents’ nutritional requirements are assessed on admission to the service, in consultation with the residents and family/whānau. The nutritional assessments identify residents’ personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. Copies of individual dietary preference were available in the kitchen folder. The menu follows summer and winter patterns in a four-weekly cycle. The menu is use was reviewed by a registered dietitian on 6 May 2024 and the food control plan was current.  Diets are modified as required and the kitchen staff confirmed awareness of the dietary needs of the residents. Snacks and drinks are available for residents throughout the day and night when required. Family/whānau and residents interviewed indicated satisfaction with the food service. |
| Subsection 3.6: Transition, transfer, and discharge  The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support. | FA | Transfers and discharges are managed efficiently in consultation with the resident, EPOA, family/whānau and the GP. Appropriate documentation and relevant clinical and medical notes were provided to ensure continuity of care when residents were transferred. The reason for transfer was documented on the transfer records and progress notes in the sampled files. The transfer and discharge planning included risk mitigation and current needs of the resident. |
| Subsection 4.1: The facility  The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people’s sense of belonging, independence, interaction, and function. | FA | The planned maintenance schedule includes testing and tagging of electrical equipment, resident’s equipment checks, and calibrations of the weighing scales and clinical equipment. The scales are checked annually. Hot water temperatures were monitored weekly, and the reviewed records were within the recommended ranges. Reactive maintenance is carried out by the maintenance officer and certified tradespeople where required. The environmental temperature is monitored and there were implemented processes to manage significant temperature changes. The building warrant of fitness was completed, and the service was waiting for the building warrant of fitness certificate to be reissued. A letter dated 30 May 2024 was reviewed to confirm the building warrant of fitness certificate was in progress to be reissued.  The environment is inclusive of people’s cultures and supports cultural practices. Residents can bring personal items to furnish their rooms. |
| Subsection 5.2: The infection prevention programme and implementation  The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | FA | The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control and antimicrobial (AMS) programmes are reviewed annually and are linked to the quality and business plan. The online infection control manual from Bug Control outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training, and education of staff. Policies and procedures are reviewed by Bug Control in consultation with infection control resource nurses. Policies are available to staff.  CHT has an outbreak and pandemic response plan (incorporating Covid-19), which includes preparation and planning for the management of lockdowns, screening, transfers into the facility, and positive tests. Staff demonstrated knowledge on the requirements of standard precautions.  The infection control resource nurses (registered nurse and clinical coordinator) oversee infection control and the antimicrobial stewardship programme across CHT Amberlea and are responsible for coordinating/providing education and training to staff. The job description outlines the responsibility of the role. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff and also available electronically. Staff have completed infection control related education in the last 12 months. The infection control resource nurses have access to online training system with resources, guidelines, and best practice. There is good external support from the general practitioner, laboratory, Bug Control, and Health New Zealand – Waitematā infection control nurse specialist. |
| Subsection 5.4: Surveillance of health care-associated infection (HAI)  The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus. | FA | Surveillance is an integral part of the infection control programme. The purpose and methodology are described in the infection control policy in use at the facility. The infection control resource nurse use the information obtained through surveillance to determine infection control activities, resources and education needs within the service.  Monthly infection data is collected for all infections based on standard definitions, signs, symptoms, and reporting criteria. Infection control data is entered into the infection register on the electronic risk management system and includes ethnicity data. The data is monitored and evaluated monthly and annually. Trends are identified and analysed, and corrective actions are established where trends are identified. There is benchmarking of infection rates with other CHT facilities that occurs monthly. Trends, benchmarking, along with actions and outcomes, are discussed at the quality, health and safety meetings and registered nurse meetings. However, general staff have limited access to information due to irregular staff meetings. Meeting minutes and graphs are not displayed on noticeboards for staff to review (link 2.2.2). The area manager acts as conduit to report any infections of concerns to the CHT quality and risk manager.  At the time of the audit, the facility had a Covid-19 outbreak; the only outbreak (with more than two residents) since previous audit. There were six previous Covid-19 events, where one or two residents had been affected (January- December 2023). The outbreak started earlier in May and has affected a total of 28 residents. On the audit day, there were three residents who were still in isolation. The outbreak was cleared at the end of the second day of the audit. The outbreak is being well managed with appropriate resident care implemented, documentation completed as per required standard, and working alongside the GPs, Public Health and Health New Zealand – Waitematā.  PPE is available for staff and visitors and was noted to be appropriately used during the outbreak. Visitors to facility are notified of the outbreak, asked not to visit if they are unwell, and masks available for use on entry to the facility. |
| Subsection 6.1: A process of restraint  The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | FA | The governance body are aware of their responsibilities in respect of restraint use minimisation. Restraint minimisation and safe practice is linked to the organisational quality and risk management strategies. Restraint information is presented at staff meetings and in quarterly health and safety meetings. The unit manager and clinical coordinator described strategies in place to eliminate and maintain a restraint-free environment, including the use of alternative methods. Restraint is reported to the Board every month through the milestone report. There are strategies in place to eliminate the use of restraint.  At the time of the audit, there was no restraint in use. Staff have received education on dementia, challenging behaviour management, restraint minimisation, alternative cultural-specific interventions, and de-escalation techniques. |

# Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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)** |
| Criterion 2.2.2  Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care. | PA Low | Although there were quality health and safety meetings held quarterly, the general staff meetings did not occur as planned. There are monthly infection, and monthly quality reports documented for the area manager that include surveillance of infections rates, performance monitoring (including the clinical indicator data), and corrective actions. In return, the area manager provides graphs related to benchmarking of CHT Amberlea with the rest of the organisation. There are quarterly quality and health and safety meetings (committee). Registered nurse meetings occur monthly and registered nurses interviewed felt well informed of what is happening within the facility. General staff meetings are scheduled monthly; however, the general staff meetings occurred six times since November 2022.  Healthcare assistants interviewed confirmed they do not see the monthly infection, quality or benchmarking reports. Staff interviewed stated there is a lack of fluid approach to communication within the facility and they rely on handovers for information. | (i). The monthly general staff meetings have not occurred as planned.  (ii). Meeting minutes and graphs are not displayed on noticeboards for staff to review. | (i)-(ii). Ensure to focus on improving staff engagement with the quality and risk management programme.  90 days |
| Criterion 2.2.4  Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them. | PA Moderate | CHT Amberlea has quarterly quality and health and safety committee meetings. The hazard register is reviewed quarterly. The forum provides for discussion in relation to completed hazard identification forms and strategies to eliminate and minimise hazards within the facility.  During a facility tour, it was observed that there was a clean linen cupboard in the downstairs unit; the cupboard also provides storage for the dirty linen trolley. Attached to the trolley was incontinence products in a double bag. The health and safety representative interviewed stated the issue was identified a couple of months ago, with a hazard form completed; it was identified that this is normal practice due to a lack of storage. There were no strategies implemented to minimise/ eliminate the hazard. | There were no response to an identified internal risk related to the storage of dirty linen trolleys. | Ensure to implement an appropriate response in relation to the storage of dirty linen trolleys.  90 days |
| Criterion 2.3.4  Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services. | PA Low | There is a two-yearly training schedule with compulsory and additional topics scheduled. Currently there is a hybrid of education and training platforms and CHT is working towards amalgamating the platforms. Staff are reminded to complete certain topics on the online platform. The training records reviewed evidence that staff are enrolled for topics; however, have not always completed the topics when required. More than 50 percent of enrolled staff have not completed the relevant Te Tiriti and cultural awareness training.  The ARRC E4.5(f) states `You must ensure that each caregiver directly involved in caring for Residents in your Dementia Unit achieves the following unit standards (or any unit standards registered in accordance with the Education and Training Act 2020 on the national qualification framework in substitution for a listed unit standard) no later than 18 months after their appointment.’  Twenty-three staff are currently rotated through the dementia unit. Ten healthcare assistants have completed the level four limited care pathway (LCP) dementia unit standards, and nine healthcare assistants are in progress (all have worked in the unit for less than 18 months). However, four has been working in the dementia unit for longer than 18 months and not yet enrolled. | (i). More than fifty percent of staff enrolled for Te Tiriti and cultural awareness, and abuse and neglect training is overdue for completion.  (ii). There are four HCAs employed in the dementia unit who have not yet enrolled for the required dementia training within 18 months to meet ARRC E4.5(f). | (i). Ensure staff complete all the compulsory training modules as per the training plan.  (ii). Ensure all staff employed in the dementia unit enrol and complete the required dementia training to meet the ARRC contract.  90 days |

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

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

|  |
| --- |
| No data to display |

End of the report.