

# Sunrise Healthcare Limited - West Harbour Gardens

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## 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Sunrise Healthcare Limited
<b>Premises audited:</b>	West Harbour Gardens
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 22 January 2020      End date: 22 January 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	56

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# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

West Harbour Gardens is one of three facilities owned by Sunrise Healthcare. The facility provides rest home, dementia, hospital (geriatric and medical) and residential disability -physical level care for up to 74 residents. On the day of the audit there were 56 residents.

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

The facility manager has previous experience in age care and is supported by a clinical manager who has recently been employed. They are supported by registered nurses and long-standing staff. Residents and relatives interviewed were very complimentary of the services and care they receive.

The service has addressed eight of nine shortfalls identified at the previous partial provisional audit around the transition plan, staffing, and environmental shortfalls. There continues to be an improvement required around contractual timeframes.

The previous certification audit shortfall around education continues has been addressed.

This surveillance audit identified areas for improvement around complaint management, care plan interventions and monitoring, medication management and restraint documentation.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. A register of complaints is kept.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Operational and clinical management and leadership is provided by the newly appointed facility and clinical managers.

There is a documented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the managers. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme is implemented.

Human resource policies are documented. An orientation programme is in place for new staff. An annual staff education and training plan is documented. Registered nursing cover is provided on a morning and afternoon shift, seven days a week with adequate numbers of care staff on each wing. Staff in the dementia unit are training in dementia.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and plans residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans demonstrated service integration and resident/relative input into care.

A diversional therapist oversees the activity team and coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and relatives reported satisfaction with the activities programme

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for the administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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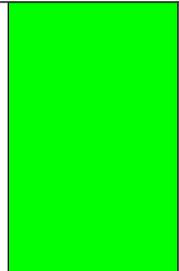
The building has a current building warrant of fitness in place. Reactive and preventative maintenance schedules were in place and maintained. The dementia unit is fully completed and secure. Outdoor areas were well maintained and easily accessible to all residents using mobility aids. There are large communal areas, and smaller seating areas available.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Staff regularly receive training around restraint minimisation and the management of challenging behaviour. Restraints were used in the service on audit day and there was one enabler used in the service.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have not been any outbreaks since the previous 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)
<b>Standards</b>	0	14	0	4	1	0	0
<b>Criteria</b>	0	43	0	4	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission.</p> <p>Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that has been reinstated in 2020. This includes complaints received, dates and actions taken as per the complaints. The facility manager signs off each complaint when it is closed. There is evidence of complaints being discussed in the staff meetings.</p> <p>Nine complaints were received in 2019. One complaint was documented as resolved as resolved in a timely manner. Documentation to confirm that complaints are resolved was not sighted.</p> <p>There is one complaint from the Health and Disability Commission that occurred prior to the last certification audit. The service is waiting for feedback from the Commission to close off the complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 12 adverse events reviewed indicated that family are kept informed. Three family members interviewed (including two with family members in</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>the hospital, one of whom is a young person with a disability; and one family member in the dementia unit) confirmed they are notified following a change of health status of their family member.</p> <p>Monthly family/resident meetings provide a venue where issues can be addressed.</p> <p>Nine residents were interviewed including seven requiring hospital level care (including two young people with disability and one under a long-term conditions contract) and two rest home residents. All stated that there was good communication with staff and managers, and they felt informed of changes in the organisation. One resident interviewed particularly stated that they valued the meetings as a way of communicating any areas for improvement.</p> <p>An interpreter service is available and accessible if required. Families and staff are utilised in the first instance. A range of communication methods are available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>West Harbour Gardens residential care provides care for up to 74 residents with 56 beds occupied on the day of audit (20 rest home, 29 hospital, 7 dementia). This is one of three aged care facilities owned and managed by Sunrise Healthcare. The service is certified to provide hospital (medical, geriatric), rest home, residential – physical/intellectual disability level care and dementia care. All hospital/rest home resident rooms are dual-purpose. There are four wings as follows:</p> <p>Kowhai is a 25-bed unit with 18 beds occupied.</p> <p>Rata is a 25-bed unit with 21 beds occupied.</p> <p>Ngaio is a 12-bed unit with 10 beds occupied.</p> <p>Manuka is a 12-bed dementia unit with seven beds occupied including one private day stay resident.</p> <p>Note: that two designated dual-purpose rooms in the hospital rest home wings are currently used as lounges.</p> <p>A transition plan for the new dementia unit has been completed. This is an improvement since the previous partial provisional audit.</p> <p>A 2019 business plan was documented for the service and this is currently being reviewed in preparation to the 2020 plan being developed. A quality plan is in place for 2020 with objectives and goals.</p> <p>A vision, mission and objectives with anticipated outcomes is documented. The facility and clinical managers interviewed confirmed knowledge of the vision, mission and values and were able to give examples of how these were implemented.</p> <p>The facility manager is a registered nurse with a current annual practicing certificate who has been in the role for two months. She has had over 13 years' experience in management roles, has been a needs assessor for a district health board and has worked in the disability sector for over 20 years in mental health, community and hospital</p>

		<p>settings. She is completing a Bachelor of Psychology and Counselling.</p> <p>The clinical manager has been in the role for one month and was previously a registered nurse for two years in an aged care facility (five years as a registered nurse in New Zealand).</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>An established quality and risk management system is documented. Quality and risk performance is reported through meetings held throughout the facility with evaluation of the plan against goals completed quarterly. Discussions with the facility manager, clinical manager and staff (four caregivers representing each level of care; two registered nurses and one enrolled nurse; a chef and kitchen assistant; maintenance and a diversional therapist), showed staff involvement in quality and risk management processes. Young people with disabilities have input into quality improvements to the service with examples provided.</p> <p>Resident and family meetings are held each month. Minutes are maintained. Annual resident satisfaction surveys were last completed in 2019.</p> <p>Young people interviewed stated that they were happy with the service overall.</p> <p>The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed on a two-yearly schedule and these are current.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results). Corrective actions are signed off when completed.</p> <p>Health and safety policies are implemented and monitored by a health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including sensor mats, and intentional rounding. A physiotherapist assesses all new residents and has developed comprehensive transfer plans which have been reported as being successful in helping to reduce the number of falls.</p>
<p><b>Standard 1.2.4: Adverse Event</b></p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p>

<p>Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>They are signed off by the clinical manager when complete.</p> <p>A review of 12 accident/incident forms showed forms were fully completed and include follow-up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are recorded for any suspected injury to the head or for an unwitnessed fall, however these are not completed as per policy (link 1.3.6.1).</p> <p>The facility manager and clinical manager were able to identify situations that would be reported to statutory authorities including infectious diseases, serious accidents and unexpected death. There was evidence of section 31 reports completed for pressure injuries and relevant authorities were notified of the change in facility and clinical managers.</p> <p>Since July 2019, registered nurses have improved reporting of any injuries or infections to family as confirmed by family interviewed and a review of incident forms. The facility and clinical managers state that they meet with registered nurses and discuss any incidents or accidents on a daily basis to ensure that there are effective processes in place to ensure that any issues are able to be discussed and escalated (link to 1.3.3.3 and 1.3.6.1).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (facility and clinical managers; three registered nurses, one caregiver; one diversional therapist and one chef) included a recruitment process (interview process, reference checking, police vetting), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies as part of their induction to the service. A new staff member was able to describe a comprehensive orientation programme that had been provided prior to them working alone.</p> <p>Performance appraisals were up to date in four of five staff files reviewed with one outstanding (all other staff files reviewed were for new staff). The facility manager is aware of staff who have not had a performance appraisal in the last year and is working to a plan to address this. This is appropriate given the length of time the facility manager has been in the service.</p> <p>Registered nurses are supported to maintain their professional competency. There are four registered nurses who are interRAI trained as well as the clinical manager. Three are booked onto the interRAI training programme. There are implemented competencies for registered nurses including (but not limited to) medication, syringe driver, wound and insulin competencies. Registered nursing staff also attend specific in-service training programmes (eg, delirium, advanced care planning, wound management and care) with high attendance rates.</p> <p>There is an annual training plan. All staff are requested to participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session.</p>

		<p>Staff complete a competency questionnaire following a selection of in-services (eg, manual handling, code of rights, hand washing, fire evacuation). Attendance has improved with the use of an online training platform.</p> <p>There are 23 caregivers with the following Careerforce training completed: fifteen level 1; five level 2; six level 3; three level 4 (plus five enrolled and five who have not completed training and are not enrolled). The staff in the dementia unit who have not got level four training and are not enrolled, work alongside a staff member in the dementia unit who has, and the registered nurse also supports their practice. The service is working towards ensuring all staff who work in the dementia unit have the required qualifications within 18 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN on site at any time. Activities are provided over five days a week. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as observed during the audit. The clinical manager is available five days a week (Monday – Friday) and is supported by the facility manager five days a week. They alternate on-call between them.</p> <p>There are staff who have completed NZQA training in dementia care. The rosters were reviewed for the past three months and all showed that staff were allocated to meet resident needs, acuity and numbers. This is an improvement on the previous partial provisional audit. The roster is designed to include a mix of levels one, two, three and four staff on each shift. There has been a nil staff turnover since the last audit.</p> <p>The following staff are rostered on:</p> <p>Manuka (dementia) has seven beds occupied and one private day stay resident. Two healthcare assistants each on the morning and afternoon shifts (one long shift and one short shift) and one overnight with a registered nurse who sits in the unit for two hours a day completing paperwork and supporting staff and residents;</p> <p>Kowhai has 18 beds occupied - 17 hospital (including seven young people with disability, two intellectual disability, one resident under the long-term condition contract) and one rest home resident. Four caregivers each on the morning and afternoon shifts (two allocated to each wing on each shift with two long and two short shifts);</p> <p>Rata has 21 beds occupied - 7 hospital (including three young people with disability) and 14 rest home residents (including one resident under the long-term condition contract). Two caregivers on each of the morning and afternoon shifts (one long and one short shift each on morning and afternoon);</p> <p>Ngaio has 10 beds occupied - five hospital (including two young people with disability, two hospital residents, one hospital resident under the long-term condition contract) and five rest home residents. One long and one short shift on each morning and afternoon shift.</p> <p>Night: Three healthcare assistants 11 pm-7 am (one allocated to the dementia unit; two across the rest home/hospital and one registered nurse).</p>

		<p>The staff in the dementia unit carry a personal alarm that is linked to staff in the rest home/hospital wings.</p> <p>Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide adequate support. Residents and family interviewed also reported there are sufficient staff numbers to meet resident needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses have been assessed for medication competency on an annual basis. Caregivers with level 4 NZQA complete competency assessments for the checking and administration of medications. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The service uses robotic rolls, and these are checked on delivery against the paper-based medication charts. Standing orders are not used. Verbal orders are used, correct procedure was followed as documented in the medication charts. One rest home resident and one hospital level of care resident were self-medicating inhalers and had self-medicating competencies in place authorised by the GP and reviewed three monthly. The medication fridge temperatures had not been recorded in both treatment rooms, and no recording of room temperatures had been completed. All medications are stored safely. Eye drops were dated on opening and all stock was within the expiry dates.</p> <p>Twelve paper-based medication charts reviewed (two YPD, one intellectual disability, three dementia, three rest home and three hospital) met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. All medications had been administered as prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals and baking are prepared and cooked on site by a qualified cook, who is supported by morning and afternoon kitchenhands. There is a four-weekly menu which has been reviewed by a dietitian in October 2019. Fridge, chiller and freezer temperatures are taken and recorded daily. End-cooked food temperatures are recorded. Inward chilled goods have temperatures checked on delivery. Cleaning schedules are maintained. Chemicals are stored safely. Kitchen staff were observed to be wearing correct personal protective clothing. The food control plan is in place expiring 30 April 2021. Food services staff have completed training in food safety and hygiene</p> <p>The main kitchen is adjacent to the main dining room and meals are served from the bain marie directly to the residents in the dining room. Meals are plated and covered with insulated lids and delivered to the dementia unit. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements (diabetic desserts and lactose free diets), cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Staff were observed assisting residents with their meals and drinks. Snacks are available for residents in all of the areas 24/7. There is a fridge in the dementia unit with nutritious snacks available 24/7.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed</p>

		alternative food choices were offered for dislikes.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP, dietitian or nurse specialist consultation. There is evidence that relatives were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with relatives and notifications were documented in the electronic progress notes. Short term care plans were documented in the electronic system for acute needs.</p> <p>Not all interventions required were readily available in the resident care plans, and not all monitoring charts were consistently recorded as instructed in the care plans. The incident reports reviewed had evidence of registered nurse follow-up and linked to wound charts as appropriate, however not all neurological observations had been completed according to the policy</p> <p>Adequate dressing supplies were sighted in the treatment room. An electronic wound register is maintained. On the day of the audit there were 16 wounds across all service levels. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds including six skin tears, three chronic ulcers, five abrasion/excoriation areas, one nailbed and one blister.</p> <p>There was one resident with one stage 3 pressure injury and one resolving unstageable pressure injury (section 31 notifications have been completed) and the wound care specialist has had involvement. There is a range of pressure injury prevention equipment readily available and in use. The two hourly monitoring charts were in place, however not consistently recorded.</p> <p>Contenance products are available and resident files included a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, restraint and challenging behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	FA	<p>The service has a qualified registered diversional therapist (DT) who works 32.5 hours a week and is supported by an activity assistant to implement the integrated rest home and hospital activity programme Monday to Friday. An activity assessment and plan are completed on admission for each resident in consultation with the resident/family (as appropriate).</p> <p>The activity team provide individual and group activities in the rest home/hospital area to meet the recreational preferences of the resident groups. The programme includes (but is not limited to); newspaper reading, exercises, board games, arts and crafts, sensory activities, word games, cooking, knitting club and walking groups. There are</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>weekly outings in the van. The van drivers and activity team hold current first aid certificates. Residents enjoy scenic drives to the airport, beaches and outings to community cafés, RSA and other rest homes for games and competitions. One-on-one activities such as individual walks, massage, reading and pampering occur for residents who are unable, or choose not to be involved in group activities.</p> <p>Activities in the dementia unit are mainly led by the caregivers, and include craft and colouring, housie, floor games, walks and gardening. Some activities such as entertainment, school groups visiting, and a large bingo game are combined with all residents in the large communal area in the hospital area. The DT completes the activities assessment. The 24-hour activity plan with activities the residents enjoy includes input from the RN and DT.</p> <p>Activities provided are appropriate to the needs, age and culture of the residents. The younger people are invited to attend the group activities of their interest. The activity team make daily contact with the younger people and ensure they have their recreational needs met. They have good family support and go out regularly with family or their support persons to community events and activities. A recent initiative has been around themes of the month. January was about celebrating the Chinese New Year, activities around the theme included baking Chinese cookies, making lanterns at crafts, a Chinese memory game, painting dragons, a Chinese crosswords and trivia. A van outing included visiting a Chinese restaurant for lunch.</p> <p>Community visitors include churches, inter-home visits, pet therapy, entertainers, school groups, kindie groups and haka groups.</p> <p>Families are invited to the monthly resident meetings. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. Residents interviewed were happy with the activities offered. The younger persons were happy the service ensures they continue with community and family outings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans reviewed were evaluated by the RN, however, not all had been developed or evaluated within expected timeframes (link 1.3.3.3). The GP reviews residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and acute care needs forms. The paper-based evaluations involved members of the multidisciplinary team and residents/relatives six monthly care planning meetings.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>The building has a current building warrant of fitness in place. Records of preventative and reactive maintenance are maintained. Equipment has been tagged and tested. Hot water temperatures have been recorded randomly (monthly) and are within expected ranges. The dementia unit is now secure. The dementia unit provides space for residents to wander around freely, and have access to the secure outside garden area, seating and shade is</p>

appropriate, accessible physical environment and facilities that are fit for their purpose.		provided. There are raised beds with sensory plants. The previous findings from the partial provisional audit have been addressed.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	The shared bathroom and toilet areas are within close proximity to resident rooms and communal areas. All are fitted with call bells and were fully refurbished, functional and suitable for resident use. The previous finding has been addressed.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a large main dining room where most activities take place. There are private lounges in each wing with a computer and skype available in one of the lounges. Seating and space is arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents.</p> <p>There is a large lounge area in the dementia unit along with a large dining area able to accommodate all residents, and a smaller quiet lounge in the dementia unit. Furniture has been purchased and was suitable for purpose. The previous finding has been addressed.</p>
Standard 1.4.7:	FA	There are emergency and disaster policies and procedures to guide staff. The emergency plan considers the

<p>Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>special needs of young people with disabilities in an emergency. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. No changes were required to the current fire evacuation procedures with the reconfiguration of services. Fire drills take place every six months. The trial evacuation report dated 6 December 2019 was sighted. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on site and are adequate for three days.</p> <p>Electronic call bells are evident in resident's rooms, lounge areas. Call bells were functional and present in all areas of the dementia unit including toilets and bathrooms. The previous shortfall has been addressed.</p> <p>The facility is kept locked from dusk to dawn.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Reports are extracted from Leecare (patient management system) for discussion, and graphs are charted to illustrate numbers of infections in each level of care. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Registered nurses discuss the surveillance data at registered nurse meetings and findings are presented at staff meetings. The number of infections is benchmarked through the district health board. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers.</p> <p>There were two (hospital level) residents using bedrails as restraint and one enabler in place.</p> <p>The resident file of the resident using an enabler was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p> <p>The restraint and enabler register was incorrect, and while there was some documentation available this did not match numbers of restraint and enablers in use as described by staff.</p>

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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>There is a complaints register for 2020 available to record complaints. Complaints for 2019 to date are documented, however there is not consistent evidence to confirm that the complainant is notified that the complaint has been received or the results of the investigation. Two complaints investigated showed that actions had been taken to resolve the issue with a letter or formal meeting to/with the complaint to discuss the outcomes of the investigation.</p>	<p>Five of the nine complaints reviewed did not include documentation to evidence resolution.</p>	<p>Ensure the complaints register records complaints, timeliness of actions with documentation confirming communication to the complainant retained.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p>	PA Low	<p>Medications were stored securely, all paper-based medication reviewed had appropriate medications charted</p>	<p>(i) Temperatures of medication fridges in</p>	<p>(i)-(ii) Ensure the</p>

<p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>correctly, there was a low usage of antipsychotic medications. Staff observed during the medication rounds were following procedures, however temperatures of medication fridges and medication rooms were not recorded.</p>	<p>both treatment rooms were not recorded. (ii) Medications room temperatures have not been recorded.</p>	<p>temperatures of the medication room and fridges storing medications are recorded and within ranges.  60 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The sample of files was extended by a further three ARC files to review contractual timeframes as the three younger persons files did not require interRAI assessments. InterRAI assessments were in place for the residents requiring this, however, not all interRAI assessments had been completed or reviewed within timeframes, and not all care plans had been developed in line with the interRAI assessment or documented as reviewed at least six monthly. This is an ongoing shortfall since the previous audit.</p>	<p>(i) Six of six ARC files reviewed did not have interRAI assessments and care plans completed or reviewed within expected timeframes.  (ii) Four of the ARC care plans were not completed in line with the interRAI assessment.</p>	<p>(i)-(ii) Ensure interRAI assessments and care plans are developed within expected timeframes.  60 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Overall, interventions in the care plans guide staff to provide adequate care for residents. Caregivers interviewed stated they had enough information in the care plans to provide the care required for residents. The care plans reviewed had resident centred goals and evidenced the care plans were developed in partnership with relatives and residents where appropriate, however, not all information was available in the care plans.  One resident had a nasogastric tube in place, instructions around this were available in the medication room, however not documented or referenced in the care plan. The resident was able to have some oral intake (as advised by the</p>	<p>(i). There were no interventions of NG tube management, advice from the dietitian, and associated risks documented in the care plan for caregivers to follow for a hospital level resident with intellectual disabilities.  (ii). Five of five unwitnessed falls did</p>	<p>(i). Ensure all required information and instructions are documented in the care plans around the maintenance and management of the NG tube.  (ii)- (iii). Ensure</p>

		<p>dietitian), however, the dietitian interventions and advice was not clearly identified in the care plan, and there was no risk or management of choking documented in the care plan.</p> <p>Incident reports and wound management plans evidenced RN follow up. Monitoring charts were in place for weight, vital signs, behaviours, neurological observations and restraint monitoring; however, these have not always been consistently completed as instructed in the care plan or as per policy.</p>	<p>not have neurological observations completed as per policy.</p> <p>(iii). The turning chart not consistently completed for a hospital level resident with a current pressure injury.</p>	<p>all monitoring charts are completed as per policy or have been reviewed by an RN prior to discontinuing.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	<p>The numbers of residents using restraint, or an enabler did not match records in the restraint folder. A register is documented; however, this does not match the numbers of restraint and enablers stated by staff.</p>	<p>The restraint folder and register is not well maintained with accurate numbers documented.</p>	<p>Ensure that there is an accurate record of restraint and enabler use maintained with relevant records retained.</p> <p>90 days</p>

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

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

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

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

No data to display
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End of the report.