

North Health Limited - Hummingbird House

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 The DAA Group 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:

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| Legal entity: | North Health Limited |
| Premises audited: | Hummingbird House |
| Services audited: | Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 11 August 2021 End date: 11 August 2021 |
| 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: | 21 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

General overview of the audit

Hummingbird House currently provides rest home level care and dementia care for up to 22 residents. The service is operated by North Health Ltd (the owners) and is managed by a manager who is also a registered nurse, with support from an RN. There are plans to change the facility to dementia level care only for up to 43 residents, however this is still in the planning and approval stages with no definitive timeframes. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of relevant policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a nurse practitioner from the local medical centre.

This audit has resulted in five areas identified as requiring improvement relating to medication charts and care planning for the current facility and fire evacuation plan approval, laundry documentation and painting relating to the new staff bathroom area for the yet to be occupied new dementia unit. Improvements from the previous certification audit and the recent partial provisional audit around chemical storage, inside seating, outside access and the display of the current building warrant of fitness have all been completed.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Open communication between staff, residents, and families is promoted. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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| 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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Business and quality and risk management plans included the scope, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Residents are assessed before entry to the service to confirm their level of care. The registered nurses (RNs) are responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs. Interventions are appropriate and evaluated promptly. Twenty-four behaviour management plans are developed as required.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whanau, residents, and staff. Residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medicine management system in place. The organisation uses an electronic system in e-prescribing, dispensing, and administration of medications. The general practitioner (GP) is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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There was a current building warrant of fitness.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs if required. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 16 | 0 | 2 | 3 | 0 | 0 |
| Criteria | 0 | 40 | 0 | 2 | 3 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | <p>The complaints/compliments policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed had been kept appropriately since February 2021 when the new owners took over running of the facility. Previous records were unable to be located by the current staff. The register showed that no complaints have been received over the six months since ownership changes at the facility but four concerns had been directly sent to the DHB, who had put them through their own complaints system, with copies of all actions through to the agreed resolution sent to the facility. Most were concerning the construction work in progress which the manager is actively managing with the least possible disruption to residents.</p> <p>The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the new ownership was finalised.</p> |

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| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>All family members stated they were kept well informed about any changes to their/their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews This was supported in residents' records sampled.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Personal, health and medical information is collected to facilitate the effective care of residents. Each resident had a family or next of kin contact log in their records.</p> <p>There were no residents who required the services of an interpreter; however staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</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> | FA | <p>The strategic / business plan for 2019 - 2021 was reviewed. It clearly outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. The manager meets at least fortnightly with one of the owners where the documents showed adequate information to monitor performance is reported, including emerging risks and issues and monitoring of quality with relevant trends.</p> <p>The service is managed by a facility manager who holds relevant qualifications. The person has been contracted in the role for two months but has been with the facility in the capacity as an RN with the previous owners and as a co-manager with the current owners. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager confirmed knowledge of the sector, regulatory and reporting requirements and has met the required professional development hours to maintain an APC. The manager is also active in a group working with other regional providers.</p> <p>The service holds active contracts with the DHB, MoH and ACC for aged residential care (rest home level), and secure dementia services, which also includes respite, and a respite care contract with ACC. Twenty one residents were receiving services under the contract (10 under the dementia care contract, 10 under the aged residential care contract and one under the ACC respite contract) at the time of audit.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p> | FA | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes and clinical incidents including infections and restraint.</p> |

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| <p>maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings, which also include all the quality data. Staff reported their involvement in quality and risk management activities through audit activities and the training programme.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey did not raise any specific issues. As the facility is very small, interaction with families is regular and resident meetings occur, so any issues are dealt with through those channels effectively.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner as well as staff.</p> <p>The manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one Section 31 notification of a significant event made to the Ministry of Health. This has been resolved appropriately.</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</p> | <p>FA</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of</p> |

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| of legislation. | | <p>completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Most care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme.</p> <p>Staff working in the dementia care area have either completed or are enrolled in the required education. Five have completed the training and two more are enrolled.</p> <p>There is a trained and competent registered nurse who is maintaining annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Not all staff files had performance appraisal information available from the previous owner but any staff who had not already completed these this year, were scheduled to have these in the next two 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> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of two four-week roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate or is in the process of updating their current ones.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | PA Moderate | <p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>Indications for use are noted for pro re nata (PRN) medications, allergies are indicated, and photos were current.</p> <p>Medication competencies were completed annually for all staff administering medication.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Medications were stored safely and securely in the trolley and locked treatment room.</p> |

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| | | <p>The health care assistant was observed administering medications safely and correctly.</p> <p>There were no residents self-administering medications. Self-administration medication is not encouraged due to the residents' impaired cognitive state in the dementia wing.</p> <p>Outcomes of PRN medication were consistently documented. Administration records are maintained, and drug incident forms are completed in the event of any drug errors.</p> <p>GP three monthly reviews are not occurring as required. Medication room temperatures are not being monitored. Six-monthly controlled drug stock takes are not being completed as per policy and legislation requirements.</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>The kitchen service complies with current food safety legislation and guidelines. The food service is currently managed by one cook. The other cook resigned and the position was under recruitment. The food service is registered with current food control plan in place expiring on 9 August 2022. Meal services are prepared on-site and served in the respective wings. The menu was reviewed by the registered dietitian on 30 June 2021. The kitchen staff have current food handling certificates.</p> <p>Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained.</p> <p>The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p> | FA | <p>Five residents' files reviewed evidenced that care plans developed had interventions that were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. The RN reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person-centred.</p> <p>The clinical nurse leader (CNL) at the medical practice that attends to residents from the service was</p> |

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| desired outcomes. | | <p>interviewed in place of the GP who was away on leave. The CNL reiterated that all medical requests, follow-ups, and reviews were completed in a timely manner.</p> <p>Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | PA Moderate | <p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the activities care coordinator who has been in the role for three weeks. The coordinator has completed some diversional therapy papers in the past and reported that they were in the process of resuming the studies to complete the course. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the family.</p> <p>The activity programme is formulated by the activities coordinator, however there was no documented activities planner in place for all residents in the rest home and dementia wing. Two residents in the rest home had no activities care plans in place. Two residents in the secure wing had no twenty-four-hour activity plans in place. Activities were being completed on an ad hoc basis. The activities were reported to be varied and appropriate for people living with dementia and those assessed as requiring rest home level of care. Residents' activities care plans were evaluated every six months or when there is any significant change.</p> <p>The residents were observed participating in a variety of activities on the audit days. Family members and residents reported overall satisfaction with the level and variety of activities provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants are reported to the nursing team in a timely manner.</p> <p>Each resident's care plan and InterRAI assessment is evaluated, reviewed, and amended either when clinically indicated by a change in the resident's condition or at least every six months whichever is earlier. The evaluation reflected the achievement of the set goals over the previous six months. The evaluations are carried out by the RN in conjunction with the family, residents, GP, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Short-term care plans were reviewed weekly or as indicated by the degree of risk noted during the</p> |

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| | | <p>assessment process.</p> <p>Interviews verified residents and family/whānau are included and informed of all changes.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Previous improvements required have now been met.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness (expiry date: 1 May 2022) was publicly displayed. All previous requirements relating to outside access and outdoor furniture in the current lodges occupied have now been met.</p> |
| <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> | PA Low | <p>A previous corrective action around the number of toilets and shower blocks has been addressed. However, a DHB review made the week before the audit, raised an issue in the new dementia wing that is currently unoccupied to needs to be followed up by the organisation around painting in the new staff area.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p> | FA | <p>Adequate seating has now been provided for all residents in the lounge areas.</p> |

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| accessible areas to meet their relaxation, activity, and dining needs. | | |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | PA Low | The laundry chemicals are now securely stored. The DHB has raised two additional concerns from their recent review in the laundry area of the new building around safety and staff guidance which need addressing. |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | PA Moderate | A previous corrective action relating to an approved evacuation plan for the planned new unit is still outstanding. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed by the RN to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits was sighted.</p> <p>Staff interviewed confirmed that they are informed of infections as they occur. The RN reported that the GP is informed on time when a resident has an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints or enablers. Enablers, when used, would be the least restrictive and used voluntarily at the residents request. If restraint is required or enablers</p> |

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| | | <p>used, a similar process is followed for both.</p> <p>Restraint would only be used as a last resort when all alternatives have been explored. There has been no use of any restraint for several years at the facility.</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) |
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| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA</p> <p>Moderate</p> | <p>The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Medication reconciliation is conducted by the RN when a resident is transferred back to the service from the hospital or any external appointments. The RN checks medicines against the prescription and these were updated on the pharmacy delivery forms.</p> <p>The policy requires that the GP completes three monthly reviews; however, seven of ten medication charts reviewed were overdue for review by a maximum of 36 days. The RN reported that the overdue medication charts were scheduled for review at the next GP visit.</p> <p>Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly; however,</p> | <p>1. Seven out of 10 medication charts sampled were not reviewed in a timely manner, the latest being 36 days overdue.</p> <p>2. The medication room temperature was not being monitored.</p> <p>3. Six monthly controlled drug (CD) stock takes were not completed as per legislation requirements.</p> | <p>Ensure medication charts, CD stocktake, and medication room temperature monitoring are kept up to date.</p> <p>30 days</p> |

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| | | <p>monitoring of the medication room temperature was not being completed. These were not part of their regular checks.</p> <p>Weekly controlled drug (CD) stock takes were evident in the drug register reviewed. Six-monthly stock takes were not consistently completed as per legislation requirements.</p> | | |
| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | <p>PA Moderate</p> | <p>Activities are conducted in the dementia and resthome wings respectively. Not all residents had activities plans and twenty-four-hour activities care plans completed and two residents in the rest home had no activities care plans in place. The activities coordinator is responsible for completing the activities programme, however there was no overall documented activities planner in place for all residents in the rest home and dementia unit. In interview conducted the activities coordinator reported that activities were decided on daily basis.</p> | <ol style="list-style-type: none"> 1. Two residents' files reviewed in the dementia unit had no 24-hour activity care plans completed. 2. Two files reviewed for residents assessed as requiring rest home level of care had no activities care plans in place. 3. There was no documented activity planner for all residents. | <p>Ensure all activity planning is current in all files and an activity planner is developed for all residents.</p> <p>60 days</p> |
| <p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor</p> | <p>PA Low</p> | <p>The new wing has had a new staff toilet and shower area completed. A previous entry into the area was through two different residents' rooms and the hallway. The DHB has asked that the paint on the new entry door be painted the same as the walls on the outside and that the two locks that had previously allowed entry from residents' rooms are disabled and those doors painted to match the rest of the room so as not to confuse residents. This was observed to be completed during the audit.</p> | <p>While the number of toilet and shower blocks is now adequate, the staff only toilet entry from the hallway is not painted in a similar wall colour. The two locks/handles on the relevant residents' rooms doors that were exits to the staff toilet area, are not disabled and painted so as not to confuse residents once the unit is operational.</p> | <p>Paint the doors not used by residents the same colours as the surrounding walls and have the locks removed from the residents' doors that are no longer used to ensure residents are not unnecessarily confused.</p> |

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| use. | | | | Prior to occupancy days |
| <p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p> | PA Low | The new laundry that is intended for use once the new unit is operating, has yet to have a security lock on the external door. In addition, the required data sheets and laundry process needed to guide staff are not yet displayed. | In the new laundry in the yet to be commissioned dementia wing, there are no guidance processes and procedures available to guide staff. There is also no appropriate security installed on the external door. | <p>Ensure appropriate data sheets and procedural documents are made available in the laundry to guide staff. Access from the external area needs to have appropriate security installed to ensure residents are not able to access that area.</p> <p>Prior to occupancy days</p> |
| <p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p> | PA Moderate | <p>There is no approved evacuation plan for the inclusion of the new unit into the facility plan. This previous corrective action is currently being worked on with urgency by the facility in conjunction with the DHB, the fire service and a contracted safety provider. It relates to the change of use for the new building that is not yet in service.</p> <p>The plans and correspondence between the parties was reviewed and work is in progress to remedy all the issues that needed to be addressed. There were relevant contractors on site during the audit to do work to reinstate fire doors to deal with the smoke separation issues identified and final evacuation points for residents once the unit is operational.</p> | There is currently no approved evacuation plan for the inclusion of the new building into the facility plan. | <p>Continue with processes already in place for obtaining an appropriate approved evacuation plan from the NZFS for all areas intending to be used for residents.</p> <p>Prior to occupancy days</p> |

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| | | Appropriate fire drills and staff training have recently been completed for all buildings currently in use and a review of a recent fire alarm process confirmed a safe, timely and efficient evacuation of all current residents occurred. | | |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.