

Kaylex Care (Waipukarau) Limited - Mt Herbert 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:

Legal entity: Kaylex Care (Waipukarau) Limited

Premises audited: Mt Herbert House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 8 September 2020 End date: 8 September 2020

Proposed changes to current services (if any): Increase certified bed numbers from 42 to 45 by certifying three beds in a stand-alone existing building (chalet 3) situated close to the main facility. The beds are to be used for rest home level care only.

Total beds occupied across all premises included in the audit on the first day of the audit: 39



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Mt Herbert House provides rest home and hospital level care for up to 42 residents. The service is owned by operated by Kaylex Care (Waipukurau). Mt Herbert House is managed by a facility manager and a clinical manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Service Standards. The audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, family/whānau, the owner/director, management, staff and a nurse practitioner.

The audit also included a walk-through of a standalone building (chalet 3) to be certified, increasing the bed numbers from 42 to 45. The three beds are suitable for rest home level care only.

The areas requiring improvement from the previous audit relating to detail in residents' care plans and the restraint policy not aligned to the standards have been addressed. Areas requiring improvement from this audit relate to corrective actions plans and in chalet 3, secure storage of medicines, a call bell in the bathroom and the requirement for a building warrant of fitness and evidence from the NZ Fire Service of an approved fire evacuation scheme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services via the local DHB if required.

A complaints register is maintained with complaints resolved promptly and effectively. There has been a complaint investigation by an external agency since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Kaylex Care (Waipukurau) Limited is the governing body and is responsible for the services provided. The business and strategic plans include a mission statement, vision, values and objectives. There is regular reporting by the facility manager to one of the directors.

The facility is managed by an experienced facility manager who is a registered nurse and has been in the position for eight years. The clinical manager is responsible for the clinical service and is supported by the facility manager.

Quality and risk management systems are in place. There is an internal audit programme. Quality data is being collected, collated and analysed. Graphs of clinical indicators are available for staff to view along with meeting minutes. Adverse events are documented on accident/incident forms. Meetings including staff (quality, health and safety, infection control and restraint) are held.

The hazard and risk register evidenced review and updating of risks and the addition of new risks.

There are policies and procedures on human resources management. Human resources processes are followed. An in-service education programme is provided, and staff performance is monitored. Care staff are encouraged to complete the New Zealand Qualifications Authority Unit Standards. Staffing levels exceed the contracted requirements. The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The facility manager is on call after hours.

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 low risk.</p>
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Residents of Mt Herbert House have their needs assessed by the multidisciplinary team on admission and within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and family members reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is run by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The facility is located close to the shops and several of the younger residents walk to the shops. Mt Herbert House does not own a facility van, however, there is access to a hire van if required for resident outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and enrolled nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

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.		Some standards applicable to this service partially attained and of low risk.
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A building warrant of fitness is displayed at the front entrance. There have been no structural alterations since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using enablers and three using restraints at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	4	0	0	0
Criteria	0	38	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)
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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information is provided to residents and families on admission and there is complaints information available at the main entrance. Resident and families stated that communication about anything that is bothering them is actioned immediately.</p> <p>Review of the register and interview of the facility manager (FM) evidenced one complaint has been received from the Health and Disability Commissioner (HDC) since the previous audit. Review of documentation evidenced a complaint was received by the HDC in March 2020 about a resident's care, the environment and communication, with a request for information. A response to the HDC from the provider dated the 27 March 2020 was also reviewed. The FM advised the HDC have not yet responded to the provider's response and the investigation remains open.</p> <p>The FM is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Residents and families interviewed stated they were kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. This was supported in the residents' files reviewed. Staff understood the principles of open disclosure, which is supported by policy and procedures</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed via the local DHB when required. The facility manager advised residents' family members can act as interpreters, where appropriate. There were no residents requiring an interpreter at the time of audit.</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>Kaylex Care (Waipukurau) Limited is the governing body and is responsible for the service provided. The business and strategic plans include a mission statement, vision, values and objectives. A flow chart details the organisation's structure. The FM provides a comprehensive monthly report to one of the directors. The director and FM reported they discuss matters concerning the facility daily via phone and the director advised they visit at least two monthly.</p> <p>Mt Herbert House is managed by a facility manager who is an experienced RN in the aged care sector. The clinical manager (CM) has been in the role for 18 months, prior to the previous audit. The CM is responsible for the clinical service and is supported by the FM. Both the FM and CM are supported by one of the directors who is an RN.</p> <p>Mt Herbert House is certified to provide care to 42 hospital and rest home level care residents. On the day of the audit there were 17 hospital level care residents including three under 65 years under the chronic health contract; twenty rest home level care residents including one mental health, and three under age 65 years under the chronic health contract. Two residents are under an ACC contract. Mt Herbert has contracts with the DHB for aged related residential care, respite, long term-chronic health conditions, restore residential care and mental health and complementary care services. There were no boarders.</p> <p>Chalet 3 is one of six existing buildings with four bedrooms and associated common areas. The provider stated three of the four bedrooms would be used to accommodate residents if approved for certification. This would take the total number of beds from 42 to 45 with these three beds used to accommodate rest home level residents only.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system</p>	<p>PA Low</p>	<p>The quality and risk management plan includes risks, current controls, ongoing actions and plans, aims, and ambitions for 2020. The internal audit programme and surveys are linked to the quality indicators and evidenced monitoring and review. There was evidence of quality data being collected, collated and analysed to identify trends. Graphs of clinical indicators with trending and meeting minutes are available for staff to view in the staff room. During the Covid 19 lockdown, staff meetings were not held; however, the FM provided weekly and then fortnightly newsletters to all staff with a variety of subjects to keep staff well informed. Staff meetings have resumed, and minutes were reviewed. Corrective actions following audits have not been consistently developed, implemented, monitored and signed off as being completed to address any areas that require improvement.</p>

<p>that reflects continuous quality improvement principles.</p>		<p>Meeting minutes have no evidence of corrective actions, who is responsible and timeframes for completion. Adverse events are documented on accident/incident forms, reviewed by the CM and FM, signed and dated. Quality, health and safety, infection control and restraint are included in the staff meetings.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice and referenced legislative requirements. There is a system in place to manage the control of policies and procedures. Policies and procedures are reviewed annually and have footers that include the date reviewed. Review of the hard copy policy and procedure folder for staff evidenced all policies and procedures were current. Staff confirmed they are aware that all documentation is reviewed during January of each year, written in the communication book and that the policies and procedures provided appropriate guidance for service delivery.</p> <p>The risk and hazard register is comprehensive and included risks associated with clinical, human resources, legislative compliance, contractual and environmental risks and included actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. The FM demonstrated good knowledge concerning health and safety. Staff confirmed they understood and implemented documented hazard identification processes.</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 events on an incident/accident form. Incidents forms reviewed evidenced these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the CM and trends shared with staff through meetings. Families confirmed they are notified of incidents/accidents in a timely manner.</p> <p>The FM is aware of essential notification reporting requirements, including for pressure injuries and health and safety events. The FM advised there have been no Section 31 notifications of significant events made to external agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and</p>	<p>FA</p>	<p>Policies and procedures relating to human resource management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records, police vetting and interview documents.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the</p>

<p>meet the requirements of legislation.</p>		<p>essential components of the service provided.</p> <p>The education programme is the responsibility of the CM. Training is provided for staff and documentation showed this is provided via several ways including study days repeated twice per year, 'tool box' talks at handover and one to one training provided by the RNs. External educators also provide education. Individual certificates of training are held on staff files. Competencies are current for the management of medicines and restraint. Attendance records are maintained electronically and in hard copy. Four of the seven RNs are interRAI trained and have current competencies. Current first aid certificates were sighted in staff files.</p> <p>A New Zealand Qualification Authority education programme through the local polytechnic is available for staff who have not already completed the programme. All caregivers apart from two new ones have attained either level 3 or 4.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. Rosters were reviewed and showed staffing levels are adjusted to meet the changing needs of residents, occupancy and the environment. Staff are also consulted about any changes in workloads. Registered nurse cover is provided seven days a week over the 24-hour period. The FM is on call after hours. There are seven RNs employed, one new graduate RN who, prior to this position was a caregiver at the facility. The other RNs range from two years' experience to many years working in the aged care sector. The director stated another RN has been recruited and will start employment within the week. There are six care givers on the morning shift, four on the afternoon shift and two on the night shift. There is at least one staff member per shift with a current first aid certificate. Cleaning and laundry staff are dedicated to the roles. A diversional therapist is employed for six hours per day, Monday to Friday.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. They reported if someone is unable to work the team helps each other. The FM stated they are usually able to fill any shortfall using one of the two casual caregivers that are employed. Residents and family members reported there was enough staff on duty to provide them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</p> <p>The owner/director and FM reported chalet 3 will be staffed over the 24-hour period by care givers. All care givers rostered will have a current first aid certificate. Although there is capacity for caregivers to be rostered from the existing staff pool, the owner/director reported they will be recruiting for more care givers as required.</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>	<p>PA Low</p>	<p>The medication management policy at Mt Herbert was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The RN observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All RNs or enrolled nurses (ENs) who administer medicines are competent to perform the function they manage. Registered nurses, ENs and caregivers all complete an annual Medimap competency assessment.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-month stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP/NP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit. Appropriate processes were in place to ensure this can be managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and clinical manager (CM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Mt Herbert.</p> <p>The Owner/director stated that medication will be managed in chalet 3 by the staff member rostered on using an electronic system. Any controlled medicines will be stored in the main facility and managed from there by the RN. Chalet 3 does not have a secure area to store medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on the 25</p>

<p>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>		<p>November 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan issued by The Ministry of Primary Industries (MPI) is in place and expires 27 June 2021. No onsite audit of the food control plan has been carried out due to Covid-19 restrictions. Mt Herbert is following up to contract someone to do the onsite audit.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. This is current and is due to be updated this year.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.</p> <p>The owner/director advised residents will be able to have their breakfast and evening meals in chalet 3. Residents will be able to choose whether they have the lunch time main meal in the main facility or in chalet 3. An appropriate trolley with the ability to keep meals hot will be used between the main kitchen and chalet 3.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed at Mt Herbert reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. This evidence addresses a previous corrective action whereby care plans reviewed did not always describe fully the support required to address resident's needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified the provision of care to residents of Mt Herbert was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>individualised and often complex needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was 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>	<p>FA</p>	<p>The activities programme is provided by a diversional therapist who works five days a week.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated regularly and as part of the formal six months care plan review. The activities programme addresses the needs of those residents under sixty-five years, by enabling them opportunities to be involved in the community as they choose.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included darts, scrabble, bingo, bowls, boccia, canine friends' visits, visiting entertainers, quiz sessions and daily news updates. Mt Herbert is a member of the Central Hawke's Bay activities group. This group is comprised of several aged care activities personnel who meet to discuss activity opportunities. Additionally, each member's home puts on two activities a year for all other members to attend.</p> <p>The activities programme is discussed at the three-monthly residents' meetings and minutes reviewed indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the services Mt Herbert provides. Feedback is used to improve the range of activities offered. Residents and residents' family members, confirmed they find the programme meets their needs.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss, behaviour management and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other short-term care plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any</p>

		resulting changes.
<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>	PA Low	<p>A building warrant of fitness is displayed in the main facility that expires on the 1 April 2021. There have been no structural alterations relating to the main facility since the previous audit.</p> <p>Chalet 3 is one of six existing chalets and is situated closest to the main building and suitable for residents assessed as requiring rest home level care. The other five chalets are further away from the main facility. Chalet 3 consists of four good size bedrooms, one of which will be a quiet room, a good size lounge/dining room, a bathroom with a walk-in shower and grip rails, a kitchen and laundry facilities. Equipment including beds and chairs are suitable for older people. There is an existing ramp to the entrance to chalet 3 with handrails. A flat concrete path leads to the main facility.</p> <p>Chalet 3 does not have a building warrant of fitness and hot water temperatures recorded.</p>
<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 Low	<p>Call bells in chalet 3 are situated in all bedrooms, and common areas. The call bells are also connected to the call bell panel in the main facility. There is no call bell in the bathroom and the existing call bells require cords connected so that residents can reach them for assistance if needed.</p> <p>Chalet 3 does not have an approved fire evacuation scheme approved by the New Zealand Fire Service. Staff rostered in the area will be required to have a current first aid certificate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Mt Herbert House is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The CM reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>Due to the Covid-19 risks at the time of audit, visiting hours are restricted at Mt Herbert, and a security guard</p>

		<p>monitors the health status of visitors entering the facility.</p> <p>The service has a good supply of personnel protective equipment to ensure the facility can isolate any residents who are an infection risk. The HBDHB is supportive of Mt Herbert in assisting to meet their needs.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>On the day of audit, three residents were using a restraints. No residents were using enablers. Staff demonstrated an understanding of their philosophy of no restraint use, exploring alternatives whenever possible, and if not possible, using the least restrictive option available.</p> <p>Restraint approval group minutes were available, and these showed quarterly meetings. Interviews with staff members confirmed that they have regular annual training and new staff have training during their orientation.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint policy includes responsibilities for the restraint process and approval. The policy has also been expanded to include guidance for the restraint approval group in terms of completing a quality review. An assessment form has been developed and implemented. Restraint use is also reviewed monthly by the approval group and three monthly by the GP.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	<p>Although there is some evidence of corrective action plans being developed following completion of internal audits, this was not consistent. There was no evidence that those audits that did have corrective actions have been reviewed for effectiveness. Minutes of meetings had no evidence of corrective actions, who was responsible and timeframes for completion.</p>	<p>Internal audits evidenced corrective actions are inconsistent and meeting minutes evidence no corrective actions, responsibility for the action and timeframes.</p>	<p>Provide evidence that corrective action plans are developed and implemented for all deficits identified.</p> <p>60 days</p>
<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</p>	PA Low	<p>Medicine management systems are in place at Mt Herbert House, however the medication policy will require updating to reflect the changes to include chalet 3.</p> <p>Chalet 3 does not have an area that is secure for the safe storage of medicines.</p>	<p>There is no secure area in chalet 3 for the safe storage of medicines and the medication policy has not been updated to include</p>	<p>Provide evidence of a secure area for the safe storage of medicines and the medication policy has been updated.</p>

with legislation, protocols, and guidelines.			chalet 3.	Prior to occupancy days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	There was no building warrant of fitness for chalet 3. The testing of hot water temperatures at outlets used by residents have not been undertaken.	Chalet 3 does not have a current building warrant of fitness and hot water temperatures have not been taken and recorded.	<p>Provide evidence that chalet 3 has a current building warrant of fitness and hot water temperatures are recorded and meet the required temperature of 45 degrees Celsius or less.</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 Low	Chalet 3 does not have an approved fire evacuation scheme approved by the New Zealand Fire Service.	An approved fire evacuation scheme was not available for chalet 3.	<p>Provide evidence that an application has been submitted and approved by the NZ Fire Service for the evacuation scheme for chalet 3. Ensure all care givers rostered to chalet 3 have current first aid certificates.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	The common areas and all bedrooms in chalet 3 have call bells. Call bells are also connected to the call bell panel in the main facility and have a different ring and light up in a different colour. There is no call bell in the bathroom and the existing call bells need cords connected so that residents can reach them for assistance if needed.	There is no call bell in the bathroom and the existing call bells do not have cords attached.	<p>Provide evidence that a call bell has been installed in the bathroom and cords have been attached to the existing call bells in chalet 3.</p> <p>Prior to occupancy days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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

End of the report.