# Sunrise International Funds Limited - Howick Manor

## Introduction

This report records the results of a Certification 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Sunrise International Funds Limited

**Premises audited:** Howick Manor

**Services audited:** Dementia care

**Dates of audit:** Start date: 13 August 2015 End date: 13 August 2015

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 16

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Howick Manor provides dementia level of care for up to 24 residents. On the day of the audit, there were 16 residents. The service is one of three aged care facilities owned by two owner/directors. A facility manager manages the daily operations and is supported by a full-time registered nurse. The relatives interviewed spoke positively about the care and supports provided at Howick Manor.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with family, management and staff. Improvements are required around the admission agreement, prescribing of as required medications and an aspect of medication storage.

## 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. |

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Residents' cultural, spiritual and individual values and beliefs are assessed on admission. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that family are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

The business plan outlines goals and objectives for the year. The quality programme includes an internal audit programme, monitoring adverse events and a health and safety programme that includes hazard management. Quality and risk management information is shared at staff meetings. Families are provided with the opportunity to feedback on issues during family meetings and via annual satisfaction surveys.

Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. An education and training programme is in place for staff. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing. Caregivers and family members report staffing levels are sufficient to meet residents’ needs. One full-time registered nurse is employed. She is available on call when not available on site. The residents’ files are appropriate to the service type.

## Continuum of service delivery

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

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to, or on entry to the service, that includes information on the Howick Manor’s behaviour management policy. The registered nurse is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs, outcomes and goals with the resident (as appropriate) and/or family/whānau input. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The diversional therapist and activities coordinator provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community. Residents have an individualised 24-hour activity plan developed on admission.

Medication policies reflect legislative requirements and guidelines. Care staff responsible for administration of medicines complete education and medication competencies. All meals are prepared on site. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours a day for the residents. Food, fridge and freezer temperatures are recorded.

## 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. |

There are documented processes in place for the management of waste and hazardous substances. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building has a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised with access to communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. Fire drills are completed six monthly.

## 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. |

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. The service had one resident assessed as using a restraint. No residents were using an enabler. A register is maintained by the restraint coordinator. Restraint use is evaluated three monthly by the restraint coordinator and integrated committee group. Staff regularly receive education and training in restraint minimisation, dementia care and managing challenging behaviours.

## 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. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is the registered nurse. The infection control coordinator has completed external training. Staff attend annual infection control education. There is a suite of infection control policies and guidelines that meet infection control standards.

## 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 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Consumers’ Rights (the Code) poster in English and Māori is displayed in visible locations. Policy relating to the Code is implemented. The facility duty manager, registered nurse (RN) and five care staff were able to describe how the Code is implemented in their everyday delivery of care.  Staff receive training about the Code during their induction to the service, which continues through the regular in-service training programme. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission and sighted in five of five resident files sampled. Advance directives if known were on the resident files. Resuscitation plans were sighted in the files and were signed appropriately. Copies of Enduring Power of Attorney (EPOA) were on all files reviewed and activated or in the process of being activated. The care staff interviewed (five caregivers, one registered nurse) were knowledgeable in the informed consent process. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is included in the resident information pack that is provided to residents (as appropriate) and their family on admission. A representative from the local HDC Advocacy Service provides education and training for staff and residents as often as twice a year. Interviews with family confirmed their understanding of the availability of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their family and friends, and community visitors such as church groups and entertainers. Residents are encouraged as appropriate to go out on van drives and outings with their families. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms and a locked suggestions box is at the entrance to the facility. Information about complaints is provided on admission. Family members confirmed their understanding of the complaints process. They confirmed that the directors, facility duty manager and registered nurse are approachable and operate an ‘open door’ policy, which was observed during the audit. Staff interviewed were able to describe the process around reporting complaints.  The complaints register included all information and correspondence related to a DHB complaint received May 2014 . The complaint was closed out in August 2014. Corrective actions taken have been embedded into practice. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information pack that is provided to residents families as part of the admission process. Information is also available at the entrance to the facility. The facility duty manager and/or RN discuss aspects of the Code with residents (as appropriate) and their family on admission.  Discussions relating to the Code are also held during the three monthly family meetings. The two families on site during the audit day reported that the residents’ rights are being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service ensures that the residents’ rights to privacy and dignity are recognised and respected at all times. The residents’ personal belongings are used to decorate their rooms. The caregivers interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They report that they facilitate the residents' independence by encouraging them to be as active as possible. Families reported the resident’s privacy and dignity is respected at all times.  Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Staff described how they would encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were no Māori residents living at the facility. One day-care resident identifies with Māori. Staff interviewed were knowledgeable in the resident’s cultural values and beliefs as identified in the resident day-care file.  Māori links have been established with a cultural advisor from Auckland University. Staff receive education on cultural awareness during their induction to the service, which continues as a regular education and training topic. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of mental decline. Beliefs and values are discussed and incorporated into the care plan, sighted in all five residents’ files reviewed. Families interviewed confirmed that they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee and are linked to their employment agreement. Job descriptions, which are signed by staff, were sighted in all six staff files randomly selected for review. Interviews with staff (five caregivers, one RN) confirmed their understanding of professional boundaries. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. Policies and procedure reflect best practice. One registered nurse is on site five days a week and on call as required. Residents are reviewed by the general practitioner (GP) every three months at a minimum.  The service receives support from the Counties Manukau District Health Board, which includes visits as needed from a range of specialty services (eg, psychogeriatrician, mental health services). Physiotherapy services are available as needed. There is a monthly in-service education and training programme for staff, which includes regularly assessing staff competencies. Podiatry and hairdressing services are available on-site. Family members interviewed expressed their satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Seven accident/incident forms for the month of July 2015 were reviewed with evidence of open disclosure documented. Interviews with the facility duty manager and RN confirmed family are notified following changes in health status. Family members interviewed stated they were kept informed of any health changes including accidents/incidents, infections and GP visits.  Three monthly family meetings provide a forum to discuss issues or concerns on every aspect of the service. The service provides information and support for families around dementia care. A guest speaker from mental health services has been scheduled for the next family meeting. Education such as fire safety is provided at family meetings (minutes sighted).  Access to interpreter services is available. An interpreter attends the family meetings for a non-English speaking family.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry, of the scope of services and any items they have to pay that is not covered by the agreement (link to finding 1.3.1.4). The information pack is available in large print and can be read to residents (as appropriate) /family who are visually impaired. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Howick Manor provides care for up to 24 dementia level of care residents and on the day of audit there were 16 residents (including one younger person). It is one of three aged care facilities owned by two directors.  There is a 2013 – 2015 business plan in place that has been reviewed annually. The plan outlines objectives for the period that includes increasing occupancy rates to 95%, staff education, ongoing maintenance plan and utilization of the outdoor areas. A five year development plan includes refurbishment of the main lounge, new furnishings, development of outdoor areas and upgrade of administration system.  A facility duty manager (non-clinical) reports to the directors and is supported by a full-time registered nurse (RN). The facility duty manager has been in post for 12 years and works full-time. The facility duty manager lives on the premises and is supported by a duty manager/qualified diversional therapist who is responsible for oversight of the activities programme at the directors three aged care facilities. The RN has been in the role for two years and has seven years work experience in aged care facilities.  The facility duty manager and both directors have maintained at least eight hours annually, of professional development activities related to managing an aged care facility. The RN has also maintained at least eight hours annually of professional development activities related to her clinical role. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The duty manager is supported by the directors (non-clinical) in her absence. The RN is supported by an RN from the directors’ other aged care facility within the area. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management system is in place. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff.  Quality data and outcomes are taken to the bi-monthly integrated committee meetings and then to the bi-monthly staff meetings, that all staff are invited to attend. Meeting minutes demonstrate key components of the quality management system, including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including three monthly family meetings. Issues arising from internal audits are reported on the Moving on Audits Action Sheet and are seen to have been closed out.  There were four responses to the annual relative survey completed in July 2015. The facility duty manager contacted families (due to low response rate) to identify any areas for improvement or dissatisfaction.  There is a health and safety and risk management programme in place including policies to guide practice. The duty manager/diversional therapist is the health and safety coordinator for all three aged care facilities. Staff accidents/incidents and identified hazards are monitored.  Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The service has lifting belts, hip protectors and access to sensor mats if necessary. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service collects incident and accident data and reports aggregated figures bi-monthly to the integrated meetings and staff meetings. Incident forms are completed by staff that either witnessed an adverse event, or were the first to respond. The resident is reviewed by the RN on duty at the time of the event or is notified by caregivers of incidents after hours.  Seven incident forms were reviewed and all were completed appropriately. The five residents’ files reviewed demonstrated all documented accident/incident forms for that resident had the events documented on an accident/incident log, held in the front of the applicable resident’s file and in the resident’s progress notes.  Discussions with the facility duty manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The RN practising certificate was current. All six staff files randomly selected for review had relevant documentation relating to employment. Annual performance appraisals were completed.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.  There is an annual education plan that is being implemented that includes selected competencies that must be completed by staff. The RN completed InterRAI training in January 2014. The RN is completing a workplace assessor course for aged care qualifications.  Twelve caregivers are employed. Seven caregivers have completed the required dementia units. Two staff have been employed over six months and less than one year and are progressing through the dementia units. Three caregivers have been employed less than six months and are registered to commence the dementia units. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the dementia residents, the facility operates a day care programme where a maximum of five residents are catered per day.  A facility duty manager is on-site full-time and available on call as required. The manager lives on the premises and is the on-call person for night staff. A full time RN is on-site Monday – Friday and on-call for clinical matters after hours. There is a laundry/cleaner Monday to Sunday. An activities coordinator is rostered Monday – Friday with the caregivers responsible for weekend activities.  Staff reported that staffing levels and the skill mix were appropriate and safe. Family interviewed advised that they felt there is sufficient staffing. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident’s individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure staff area. Care plans and notes are legible. All residents’ records contain the name of resident. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | PA Low | All residents are assessed prior to entry for secure dementia care. The duty manager is responsible for the screening of residents to ensure entry has been approved. An information booklet is given out to all residents/family/whānau on enquiry or admission. The information pack includes information on all relevant aspects of the service and other relevant information, including information on the management of challenging behaviour. The registered nurse (interviewed) was able to describe the entry and admission process. Admission agreement schedule of charges sighted in the resident files reviewed did not align with the ARC contract. The two relatives interviewed stated they received all relevant information prior to or on admission. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The registered nurse interviewed described the documentation and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation is sighted in a resident’s record, recently transferred back to the facility. The family are informed of any transfers. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | All clinical staff who administer medication have their medication competency assessed on an annual basis. Education around safe medication administration has been provided. The care staff interviewed were able to describe their role in safe medication management. Standing orders are in use and current. There were no residents self-medicating on the day of audit. Nine of ten medication charts reviewed met legislative prescribing requirements. Not all ‘as required’ medication had indications for use prescribed. The medication charts reviewed identified that the GP had seen and reviewed the resident’s medication three monthly.  Medications are managed appropriately and in line with required guidelines and legislation with the exception of the safe storage of controlled drugs. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Howick Manor are prepared and cooked on site. There is a four weekly seasonal menu, which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Additional nutritious snacks are available over 24 hours for the residents.  Family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier.  All food services staff have completed training in food safety and hygiene and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry, by the duty manager. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission that could potentially affect other residents. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | InterRAI assessments have been completed for all current residents and are completed for all new admissions. The RN completes an initial assessment on admission including the use of risk assessments and behaviour assessments. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. The activities coordinator completes an activity assessment on admission that identifies individual activities and preferences.  Cultural assessments are completed on admission for all residents. Cultural assessments were completed in all five resident files sampled. The care plans document the resident’s cultural needs, values and spirituality and supports (including support persons) available to ensure the resident’s needs are met. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident care plans reviewed were resident focused. All identified support needs were included in the care plans for five of five residents files sampled. The care plans include strategies and alternative therapies for minimising episodes of challenging behaviours over the 24 hour period. Care plans sampled evidenced resident (as appropriate) /family/whānau involvement in the care plan process. Relatives interviewed confirmed they are involved in the care planning process. Resident files demonstrate service integration. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications were documented in the resident file sampled in the family/whānau contact form. The registered nurse was able to describe the referral process should they require assistance from a wound specialist, continence nurse or other nurse specialist service.  Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for the one chronic wound. The chronic wound has been linked to the long-term care plan. There was evidence of GP, wound nurse specialist and dietitian in the management of wounds. There was adequate pressure area care equipment sighted.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service has a qualified registered diversional therapist who oversees the programme and an activities coordinator who delivers the programme. The activity coordinator provides individual and group activities. The monthly programme is varied and appropriate for people with dementia and includes activities such indoor bowls, crafts, gardening, walking groups, music, baking, and entertainment. There are regular outings/drives, for all residents (as appropriate).  Care staff were observed at various times throughout the day diverting residents from behaviours with one-on-one activity. The individual activities observed were appropriate for older people with dementia conditions. There are resources available for care staff to use for one on one time with the resident. Staff could describe a low stimulus environment.  Relatives stated they were satisfied with the activities provided and that staff were involved in activities with their loved ones, even if only passive participation.  An activity profile is completed on admission in consultation with the resident/family (as appropriate). Activity plans sighted in all five files were reviewed six monthly at the same time as the care plans. Activity participation sheets were maintained in files sampled. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans sampled were evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six monthly in five of five files sampled or earlier for any health changes. The multidisciplinary team (MDT) including the GP and family, are involved in the care plan reviews. The GP reviews the residents at least three monthly or earlier if required. On-going nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the five resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents’ files. Examples of referrals sighted were to mental health services for the older person, physiotherapist, hospital specialists, wound nurse, podiatrist and dietitian. The service liaises closely with the needs assessment team, geriatrician, and mental health team. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Chemical bottles sighted had correct manufacturer labels. Chemicals were stored correctly. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Blood and chemical spills kit are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires on 4 March 2016. Maintenance is completed by the Director who is available on call 24 hours per day for urgent matters. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and are recorded weekly with corrective actions documented for temperatures outside of the acceptable range.  There is safe access to all communal and outdoor areas. There is a secure outdoor walking pathway with seating and shade provided.  Staff stated they have all the equipment required to provide the level of care documented in the care plans.  There are quiet, low stimulus areas that provide privacy when required. A second lounge is available. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are communal use bathrooms/toilets. Communal toilet facilities have a system that indicates if it is engaged or vacant. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are only single rooms. There is adequate room to safely manoeuvre mobility aids and transferring equipment as required in the resident bedrooms. Residents and families are encouraged to personalise their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include open plan lounges and dining areas. There is a smaller lounge and/or family room within the facility. The communal areas are easily accessible for residents.  Seating and space is arranged to allow both individual and group activities to occur. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is a dedicated laundry/housekeeper seven days a week. Cleaning equipment is kept in designated locked areas. Families interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures are in place. Fire evacuation drills take place every six months. The orientation programme and education and training programme include fire and security training and staff completing competency questionnaires. Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan is in place.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and the availability of gas cooking.  The call bell system is suitable to meet the needs of the residents. There is at least one person with a current first aid certificate on duty at all times. External lighting is adequate for safety and security. The facility is secure at all times. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control coordinator is the RN who has been in the role for two years. She has a job description that defines the role and responsibilities for infection control. The infection control coordinator provides a report to the integrated committee meetings that includes infection control matters. The integrated committee includes the infection control coordinators and representatives from the three aged care facilities owned by the directors. The two directors attend the committee meetings. Meeting minutes are available to staff. The infection control programme is reviewed annually.  Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control is managed by the infection control coordinator and infection control committee representatives. The infection control coordinator has attended external education through the DHB. The infection control officer has access to an external infection control specialist, district heath board (DHB) infection control nurse, wound care specialist, community geriatric services, district nurses, public health and GP and laboratory personnel. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies and procedures were reviewed February 2015 by a contracted aged care consultant. The service is notified of any changes/reviewed policies. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education occurs annually and has included hand hygiene and wound care. All newly appointed staff receives infection control education on orientation. Hand hygiene competencies are completed annually for all staff. Staff stated they are kept informed on infection control matters at handovers and staff meetings. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control officer collates information monthly. Surveillance data is used to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is reported at the integrated committee meetings and staff meetings. Monthly comparison and trends for infection rates are analysed on an individual basis. Information and graphs are displayed for staff. The GP reviews antibiotic use at least three monthly with the medication review. There have been no outbreaks. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. Interviews with the caregivers and RN confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had no resident using an enabler and one resident using a restraint. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval form identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The restraint coordinator and facility duty manager only may approve the use of restraint if required. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator/RN in partnership with the resident (as appropriate) and their family. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  On-going consultation with the resident and family/whānau are evident. There is one resident who has a restraint (chair with feet raised). The resident file was reviewed and identified a completed assessment, which considered those listed in in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. The restraint coordinator (RN) is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident (as appropriate) and family and the restraint coordinator. The use of restraint is linked to the residents care plan. Internal audits conducted measure staff compliance in following restraint procedures. Each episode of restraint is monitored while the resident is in the chair with feet raised. Monitoring is documented on a specific restraint monitoring form and includes the time restraint on and taken off, as well as cares offered during the time of restraint. The monitoring form for the one resident with restraint use was sighted.  A restraint register is in place providing an auditable record of restraint use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur six-monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of the one file of a resident using restraints identified that evaluations are up-to-date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraints are discussed and reviewed at restraint meetings, attended by the restraint coordinator and facility duty manager. Meeting minutes include (but are not limited to) a review of the restraint and challenging behaviour education and training programme for staff and review of the facility’s restraint policies and procedures. Restraint use is discussed at the staff meetings. Staff have attended restraint and challenging behaviour education within the last year. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.1.4  Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Low | The five admission agreements have been signed within the required timeframe. The exclusions from the service were included in the admission agreement. | The schedule of charges attached to the admission agreement did not align with the provider responsibilities in the ARC contract. There was no evidence the residents had been charged for any services included in the ARC contract. | Ensure the schedule of charges aligns with the exclusions from the service as per the admission agreement.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | There are policies and procedures in place for safe medicine management that meet legislative and policy requirements. Medications are stored in a locked room. Medication reconciliation is completed on delivery of medications. Nine of 10 medication charts met prescribing requirements. Staff were observed to be safely administering medications. | i) One of ten medication charts reviewed did not have indications for use prescribed for ‘as required’ medication (Quietapine).  ii) The controlled drug key was not kept on the person responsible for medications. | i) Ensure all ‘as required’ medication has indications for use prescribed.  ii) Ensure the controlled drug key is kept on the person responsible for administering medications as per the medications guidelines.  60 days |

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

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

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

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

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End of the report.