# Sunrise International Funds Limited - Howick Manor

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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: 1 March 2017 End date: 1 March 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 21

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | 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

Sunrise International Funds Limited trading as Howick Manor provides residential dementia services for up to 24 residents and people requiring a dementia level day programme. The higher number of residents has been agreed in writing by the District Health Board. On the day of the audit, there were 21 residents (which included one person receiving respite support services) and one person attending the day programme. 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 unannounced surveillance audit was conducted against a sub-set of 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.

The service has addressed two of two shortfalls from the previous certification audit around the content of the admission agreement, prescribing of ‘as required’ medications and an aspect of medication storage.

The surveillance audit identified that improvements are required in relation to the medicines management system.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs and family state that they are fully informed at all times. Three monthly family meetings provide a forum to discuss any issues or concerns. The complaints procedure is provided to residents and relatives as part of the admission process. There have been no complaints made since the last audit.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Howick Manor has an implemented quality and risk management system. Key aspects of the quality improvement and risk management programme include monitoring of incidents and accidents, health and safety, implementation of an internal audit schedule and surveillance of infections. There is an annual family satisfaction survey. The service has policies and procedures that are reviewed by an external consultant. The service has human resources procedures for staff recruitment and employment. There is an implemented orientation programme and an implemented annual training schedule in place. Staffing levels safely meet the needs of the residents and all caregiving staff have either completed the dementia training or if newly appointed, are enrolled in the programme.

## Continuum of service delivery

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

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 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 and completes interRAI assessments. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The diversional therapist provides 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 are in place. Care staff responsible for administration of medicines complete education and medication competencies.

Meals are prepared on site by the cook and individual and special dietary needs are catered for. Nutritional snacks are available 24 hours a day for the residents. Family interviewed responded favourably to the food that is provided.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness. There have been no building alterations since the previous audit.

## 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. Environmental restraint is in place for all residents. Enablers are not used as residents are not able to agree to their use. The service has no resident using any other form of restraint.

## 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 prevention and control programme includes the surveillance programme. The programme is overseen by the infection prevention and control coordinator who is the registered nurse. Surveillance data are collected, recorded and analysed. There have been no outbreaks of infection in the period since the previous audit.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 16 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 0 | 1 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| 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). Complaints forms and a locked suggestions box is located at the entrance to the facility. Information about complaints is provided on admission. Family members interviewed confirmed their understanding of the complaints process. Three care staff interviewed were able to describe the process around reporting complaints. There have been no complaints made since the last audit. |
| Standard 1.1.9: CommunicationService 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. Twelve accident/incident forms for January and February 2017 were reviewed with evidence of open disclosure documented. Interviews with the facility duty manager and registered nurse (RN) confirmed family are notified following changes in health status. Three family members interviewed stated they were kept informed of any health changes including accidents/incidents, infections and general practitioner (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.  |
| Standard 1.2.1: GovernanceThe 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. On the day of audit there were 21 residents (including one resident on respite). Howick Manor is one of three aged care facilities owned by two directors. The service has an agreement to provide aged residential care for Counties Manukau District Health Board. It is able to provide carer support on an individual basis. It has a discretionary arrangement with the Needs Assessment and Support Coordination agency to provide a day services programme to a small number of people on an individual basis.There is a 2016–2018 business plan in place that reflects the family centred approach to care, it has been reviewed annually. The plan outlines objectives for the period that includes: increasing occupancy rates to 96%, staff education, ongoing maintenance plan and utilisation of the outdoor areas for activities. A five year development plan includes: refurbishment of the main office, new indoor/outdoor 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 RN. The full-time facility duty manager has been in position for 14 years. The facility duty manager lives on the premises and is supported by a qualified diversional therapist who is responsible for oversight of the activities programme. The RN has been in the role for one year and has several years work experience at another aged care facility. 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 1.2.3: Quality And Risk Management SystemsThe 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 prevention and control, incidents (and trends) and in-service education. 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 audits action sheet and were sighted to have been closed out. There were four responses to the annual relative survey completed in July 2016. 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. 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 committee meeting and staff meeting. 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. Twelve incident forms were reviewed and all were completed appropriately. Discussions with the facility duty manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications of events to external agencies. |
| 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 has a current practising certificate. The RN completes interRAI assessments. Five staff files (one duty manager, one RN, one activities coordinator and two caregivers) reviewed 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 practices. 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. Ten caregivers are employed at Howick Manor. Seven caregivers have completed the required dementia standards. Three caregivers have been employed less than 12 months and are enrolled to commence the dementia standards.  |
| 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 mix for safe service delivery, meeting contractual requirements. A full-time facility duty manager lives on the premises and is the on call person for night staff. A full-time RN is onsite from Monday to Friday and is on call for clinical matters after hours. There is a laundry/cleaner Monday to Sunday. An activities coordinator is rostered Monday to Friday with the caregivers responsible for weekend activities. Staff reported that staffing levels and the skill mix were appropriate and safe. Families interviewed advised that they felt there is sufficient staffing. |
| 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. | FA | All residents are assessed by the Needs Assessment and Service Coordination agency prior to admission and approved by them to receive specialist dementia services. 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 inquiry 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, minimising restraint and the consumer complaints policy.The registered nurse was able to describe the entry and admission process. The three relatives interviewed stated they received all relevant information prior to or on admission. The previous shortfall identified that the schedule of charges attached to the admission agreement did not align with the provider responsibilities in the aged residential care agreement. A review of a sample of five residents’ records showed that for residents who were admitted following the previous audit, a schedule of additional charges is included in their admission agreements. These charges align with the exclusions from the service as per the admission agreement.  |
| 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 Moderate | The service has a medicines management policy. Medicines are checked on delivery from the pharmacy and prior to use. All medicines are administered by caregivers who have been assessed as competent by the RN who has been assessed as competent. Medication competency is assessed on an annual basis by the RN. No residents were self-administrating medicines. A sample of 10 sets of medicine management forms were reviewed. The lunch time administration of medicines was witnessed. Medications were managed appropriately. The previous certification audit identified shortfalls in medicines management which related to the documentation of ‘as required’ medication and the security of the key to the medicines cabinet. Of the 10 records reviewed all ‘as required’ medicines were correctly charted, and the registered nurse held the medicines keys on the day of audit.This audit identified shortfalls in the photographic identification of residents and in the provision of standing orders. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA 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 (summer and winter), which has been reviewed by a dietitian. Resident special dietary profiles are completed with individual likes and dislikes accommodated. When residents are losing significant weight, the cook states that the kitchen is notified. Staff were observed assisting residents with their meals and drinks. 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 any dislikes. Food satisfaction surveys are completed every six months. Fridge and freezer temperatures are taken and recorded daily. Food is stored safely, labelled with contents and expiry dates are monitored. End cooked food temperatures are recorded on each meal. All food services staff have completed training in food safety/hygiene and chemical safety. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | A review of five clinical records included: four residents admitted since the last audit, including one on carer support (respite) and one attending the day programme. The fifth resident was admitted prior to the last audit. All residents had a plan of care. Assessed needs, as identified in their interRAI assessment, were included in their plans of care. A behaviour management was included, which specified prevention-based strategies for minimising episodes of challenging behaviours and described how the resident’s behaviour was best managed over a 24 hour period. The plan of care described the resident’s current abilities, level of independence, routines and behavioural characteristics. Involvement by family/whanau is encouraged. When a resident's condition alters, the RN initiates a review and if required, a GP or nurse specialist consultation. The three family members interviewed confirmed they are notified of any changes to their relative’s health. Discussions with families and notifications were documented in the resident file sampled in the family/whānau contact form. The RN was able to describe the referral process should they require assistance from a wound specialist, continence nurse or other nurse specialist services. Adequate dressing supplies are available if needed. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for one resident with a skin tear which was documented in the short term care plan. This resident was receiving carer support. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.Staff have access to sufficient communal equipment if needed (e.g., walking frames and wheelchairs). |
| Standard 1.3.7: Planned ActivitiesWhere 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 employs a qualified registered diversional therapist who oversees the individual and group activities programmes, an activities coordinator is also employed who delivers the programme. The diversional therapist and the activity coordinator provide individual and group activities. The group programme is offered from 8.30 am to 2.30 pm Monday to Sunday.An activity profile is completed on admission in consultation with the resident/family. An individual plan is developed from this range of information. A 24 hour normal activities/behavioural plan is documented. All five residents in the sample included appropriate activities documentation.The monthly group programme is varied and appropriate for people with dementia. There are regular outings/drives, for all residents (as appropriate) in the van which seats eight residents and two staff (one of whom is the driver). 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 residents. There are resources available for care staff to use for individual activities with residents. Staff could describe a low stimulus environment. Relatives interviewed stated they were satisfied with the activities provided and that staff were involved in activities. |
| 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 are reviewed at least six monthly or earlier for any resident experiencing changes in their health and indicate the response to the plan of care. The RN keeps a list of when resident reviews are due. The GP and family are involved in care plan reviews. The GP reviews the residents at least three monthly or earlier if required.  |
| 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 warrant of fitness which expires 4 March 2017. There have been no alterations to the building since the previous audit. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection prevention and control (IPC) coordinator is the RN who manages the surveillance programme. There is a policy describing the surveillance programme. The IPC coordinator collates information monthly. Surveillance data are used to determine infection prevention and control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data are reported at the integrated IPC committee meetings and at staff meetings. Monthly comparison and trends for infection rates are analysed on an individual basis. Information and graphs are developed for staff. The GP reviews antibiotic use. There have been no outbreaks of infection since the previous certification audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers. Enablers are not used as residents are not able to cognitively agree to their use. Environmental restraint is in use for all residents (including the resident receiving carer support and the person attending the day service). All environmental restraint has been pre-approved by the needs assessment and service coordination agency. At the time of the audit, the service had no residents using enablers or any other type of restraint. Interviews with the caregivers and the RN confirm their understanding of restraints and enablers. |

# 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)** |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Medicines management information is recorded on pharmacy generated forms that meet industry accepted standards. Each resident has their own set of forms. The forms were completed correctly following the administration of medicines. Allergies were noted. Six of ten residents’ records reviewed contained photographic identification, which was verified as being a current likeness by the registered nurse. Standing orders are used. | (i) Four of ten sets of medicines management forms do not contain photographs for the identification of residents. (ii) Standing orders are in use however the content and practice does not meet the Standing Orders Guidelines 2012. | (i)Ensure each resident has a photographic identification for the safe administration of medicines. (ii) Ensure Standing Orders meet the Standing Order Guidelines 2012.60 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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| No data to display |

End of the report.