

# Bima Health Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Bima Health Limited

**Premises audited:** Sunhaven Rest Home & Private Hospital

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

**Dates of audit:** Start date: 30 March 2017 End date: 31 March 2017

**Proposed changes to current services (if any):** A new wing has been built that connects to the existing building so that the two services are able to be separated. Two bedrooms situated between the two units are proposed as dual purpose rooms. Overall this will provide 16 rest home dementia beds, 22 psychogeriatric level beds and two dual purpose beds (dementia or psychogeriatric) with supporting facilities for each unit.

**Total beds occupied across all premises included in the audit on the first day of the audit: 24**

# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Sunhaven Rest Home and Private Hospital provides rest home dementia and psychogeriatric hospital level care for up to 37 residents. On the first day of audit there were 24 beds occupied (eight dementia level and 16 psychogeriatric). The facility is operated by Bima Health Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

A partial provisional audit was also undertaken to establish the level of preparedness of the provider to operate the new eight bedded extension to the existing building and two bedrooms to be available for dual purpose beds.

The areas that required improvement from the previous audit relating to corrective actions, reassessment of residents, wound management, short term care plans, restraint documents and surveillance data analysed over previous months have been addressed.

Areas for improvement that remain open relate to evaluation of care plans and the management of medicines.

Areas requiring improvement from this audit relate to meeting minutes not recording trends from analyse of quality data, interRAI timeframes not met, a code compliance certificate for the building addition, an uncovered channel for rain water between the path

and the new building, a letter from the New Zealand Fire Service approving the application for a new evacuation scheme with a plan to undertake a trial evacuation, and no call bell situated in the main lounge of the new building.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The complaints register is current and all complaints have been entered. Residents and their families reported their satisfaction with the open communication with staff. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Bima Health Limited is the governing body and is responsible for the services provided. A business management plan and a quality and risk management plan were reviewed. An organisational flow chart details the positions of staff in the organisation.

The facility is managed by a facility manager who has been in this position for 10 years. The facility manager is supported by two clinical coordinators/registered nurses who are responsible for the oversight of the clinical services in the facility. The facility is operated by the owner who has an office on site. There is daily communication between the facility manager and the owner. The clinical coordinators meet with the facility manager daily.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collected, collated analysed and corrective actions developed and implemented. Graphs of clinical indicators are available for staff to view along with meeting minutes.

Documentation, including policies and procedures have been reviewed and are current.

There are policies and procedures on human resources management. In-service education is provided for staff at least monthly. Care staff reported they have either started or completed the New Zealand Qualifications Authority Unit Standards, including the dementia modules. Competencies are current. All staff and allied health professionals have current practising certificates.

A documented rationale for determining staffing levels and skill mixes is in place to provide safe service delivery. The owner and facility manager are on call and the clinical coordinators are rostered on call after hours. Care staff reported there is adequate staff available. Registered nurses, quality and risk management, staff and residents' meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>	<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

Some standards applicable to this service partially attained and of low risk.

Building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

The new extension to the existing building has been built and will provide accommodation and supporting facilities for eight residents requiring psychogeriatric level care along with facilities already existing in the main building. The new wing and existing area will provide 22 psychogeriatric beds. The other existing area will provide 16 dementia level care beds. Two bedrooms are proposed as dual purpose beds.

There are adequate toilet and shower facilities throughout the facility.

Residents have access to several lounge areas and dining rooms. An appropriate call system is available, apart from the new lounge, and security systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

Documentation of policies and procedures and interview of the facility manager demonstrated residents are experiencing services that are the least restrictive. There is currently one resident using restraint. There are no residents using an enabler. The restraint policy and procedure has been reviewed and is now appropriate to the facility, the assessment and evaluation forms meet the requirements of the standard, and a restraint register has been developed and implemented.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	23	0	4	2	0	0
Criteria	0	55	0	6	2	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

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility.</p> <p>The complaints register showed one complaint has been received since the previous audit. Documentation was complete for the complaint and Right 10 of the Code had been followed.</p> <p>The facility manager is responsible for the management and follow up of complaints. Staff interviewed confirmed a good understanding of the complaint process and what actions are required.</p> <p>The facility manager (FM) reported there has been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
Standard 1.1.9: Communication	FA	Resident records reviewed included evidence of open disclosure and timely communication with residents and families. Communication was documented

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>in family communication sheets, on accident/incident forms as well as documentation in the residents' progress notes. Family members interviewed stated they were informed in a timely manner about any changes to the resident's status, and appreciated the ongoing communication with staff. The family satisfaction survey confirmed this. The facility manager advised that interpreter services can be accessed from the local district health board when required. Staff also speak different languages and are available to assist, as required.</p> <p>A three-monthly newsletter is sent out to families which gives good information relating to what has happened and what is happening at Sunhaven. Families stated they find the newsletters informative and enjoy reading them.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The current business management plan includes a philosophy, vision, values, a mission statement goals and market analysis. There are systems in place for monitoring the service and regular daily communication takes place between senior management and the owner. The owner works in the business and shares an office with the facility manager.</p> <p>Sunhaven Rest Home and Private Hospital (Sunhaven) is managed by a facility manager (FM) who has been in this role for 10 years. The facility manager has attended appropriate seminars since the previous audit and attends the DHB leadership forums every three months. The facility manager is supported by two clinical coordinators (CC) and the owner. The facility manager reported that personnel from the local DHB also offer support. The two clinical coordinators are experienced registered nurses (RNs) who attend ongoing education both internally and externally. Another RN who used to be employed at the facility as a CC, visits on an ad hoc basis to give support to the clinical staff and review documentation.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Sunhaven is certified to provide psychogeriatric hospital and rest home dementia care. On the first day of this audit there were 16 psychogeriatric level care residents and eight rest home dementia level care residents. A letter dated 27 February 2017 from HealthCERT showed dispensation for</p>

		<p>one resident who is hospital level care. The FM advised they were requesting an extension to the dispensation while the auditors were on site.</p> <p>Partial provisional: The owner advised that once the new wing is occupied and the two services separated, the title of clinical coordinator will change to clinical manager and it is proposed that this will be a full-time position with the CM stationed in the psychogeriatric unit.</p>
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	<p>In the absence of the facility manager, the clinical co-ordinators deputise. The clinical coordinators deputise for each other or another charge nurse takes responsibility for clinical overview. The FM and co-ordinators confirmed their responsibility and authority for these roles.</p> <p>Partial provisional: The owner advised that once the new wing is occupied and the two services separated, the title of clinical coordinator will change to clinical manager and it is proposed that this will be a full-time position with the CM stationed in the psychogeriatric unit.</p>
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.	PA Low	<p>A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and completed internal audits were reviewed. Registered nurse meetings are held six weekly and quality and staff meetings two monthly. Meeting minutes reviewed confirmed this. Staff stated they receive results of quality improvement data and discuss trends, however, there was insufficient detail evidenced in the meeting minutes to support this.</p> <p>The family satisfaction survey indicated residents and family are satisfied to very satisfied with the services provided.</p> <p>Completed audits for 2016 and 2017, clinical indicators and quality improvement data were reviewed. Review of the quality improvement data evidenced data is being collected, collated, analysed and trends identified. Corrective actions were consistently developed and implemented. There was documented evidence of follow-up to the action taken and the effectiveness. Graphing of clinical indicators was evidenced, including past month's data that enables staff to compare results month by month. The requirement from the previous audit is closed.</p>

		<p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures have been reviewed and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. An interRAI policy includes all requirements.</p> <p>Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents/family as appropriate. The health and safety coordinator is responsible for hazards. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The CC reviews these. The original is kept in the residents' files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>The FM stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting.</p> <p>The owner reported they have not made application to HealthCERT relating to changing two rooms to dual purpose beds. (See 1.4.2)</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in</p>	FA	<p>There are human resources management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>authority, employment agreements, references, orientation, current performance appraisals and police vetting.</p> <p>The facility manager is responsible for the in-service education programme. The in-service education programme for 2016 and 2017 evidenced education is provided at least monthly for staff and covers all required topics. Outside speakers are invited to present some of the sessions and staff also attend education externally. All staff have either completed or started the dementia specific modules through New Zealand Qualifications Authority Unit Standards. The FM is the facility's assessor.</p> <p>Registered nurses are responsible for medicine management. Staff files evidenced current competency assessments. Restraint competency assessment are current for all clinical staff. One RN is trained in the interRAI assessment programme and has a current competency. Another RN has almost completed the programme.</p> <p>There is an orientation/induction programme. The entire orientation process can take up to two months to complete. Orientation for staff covers the essential components of the service provided. Care staff confirmed they have completed an orientation and staff files reviewed confirmed this.</p> <p>Annual practising certificates are current for all staff and contractors who require them to practice.</p> <p>Partial provisional: The education programme includes appropriate topics for the increase in the numbers of beds and the provision of two dual purpose care.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes that provides safe service delivery. The two clinical co-ordinators are rostered on Monday to Friday 9am to 5.30pm. One co-ordinator works three days per week and the other two days per week. The clinical coordinators are responsible for the clinical service on the days they each work. Communication between the coordinators is via a diary that evidenced detailed information and through verbal communication.</p> <p>There is an RN rostered on all shifts. Three caregivers are rostered on the morning shifts and four on the afternoon shifts, one of which stays in the main lounge at all times, with an extra caregiver who 'specials' one resident.</p>

		<p>The minimum number of staff is provided during the night shift and consists of one RN and one caregiver.</p> <p>The FM reported the roster is reviewed constantly. The owner and FM are on-call after hours for non-clinical concerns. The clinical co-ordinators are rostered on after hours for all clinical concerns. Care staff reported there are adequate staff available and that they can complete the work allocated to them. Residents and families reported there was enough staff on duty that provided them or their relative with adequate care. Review of rosters and observations during this audit confirmed staff cover meets requirements.</p> <p>Partial provisional: The FM stated that once the two services are separated, the RN will be stationed in the psychogeriatric unit and the ratio of care staff to residents in the psychogeriatric unit will be higher.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>The quality improvements identified in the previous audit related to the manner in which the controlled drug register is maintained, no NHI numbers, reason for administration, dates for new medication and staff annual education have all been addressed. However, issues related to all medications having the signature of the prescriber remains open. Other issues arose related to prescriptions being documented on the incorrect section of the medication chart and no documented staff guidance for a resident receiving insulin.</p> <p>A system for medicine management using a paper based system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Staff education occurred in October 2016.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly or on request.</p>

		<p>There were no controlled drugs on site at the time of audit but there is secure storage and they are checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Not all good practice prescribing practices are undertaken and include stop dates for short course medicines, no documented staff guidance for range of blood sugar levels related to the administration of insulin, prescribed medications were not written in the correct part of the medication charts and one medication chart was not signed. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders were used, were current and complied with guidelines. There were no residents who self-administer medications at the time of audit.</p> <p>There was an implemented process for comprehensive analysis of any medication errors.</p> <p>Partial provisional: No changes are needed to the medication management system with an increase in beds.</p>
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	<p>The food service is provided on site by a dedicated kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (June 2016). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any</p>

		<p>special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>Partial provisional: The chef interviewed on the day of audit has no concerns about a possible increase of three in bed numbers as the kitchen is fully equipped and can easily cater for additional residents. The service has purchased a hot box trolley for use in the area with additional beds.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate to meet the needs of all residents. The GP stated the clinical nurse leaders are very good at their roles and they assist more junior RNs to provide all cares. The service maintains a very close working relationship and support from mental health services.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist holding the National Certificate in Diversional Therapy with assistance from caregivers.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents, as observed on the days of</p>

		<p>audit. The resident's activity needs are evaluated six monthly by the diversional therapist and information is used to formalise care planning. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Resident activity attendance information is used to evaluate and improve the programme.</p> <p>Residents confirmed the programme meets their needs. Activities are specific to meet the needs of all residents' levels of ability. The formalised programme operates Monday to Friday 11am to 5pm to cover the times residents are most physically active and/or restless. Activities include news readings, outings around the community, one on one hand massage, music and concerts, church activities, and the celebration of specific days, such as Saint Patrick's Day.</p> <p>The diversional therapist feels that an increase in bed numbers by three residents will be able to be managed by the facility.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. The formal care plan evaluations, occur every six months. However, as per the finding in the previous audit evaluations are not consistently detailed to show the residents response to interventions undertaken. This quality improvement remains open.</p> <p>Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are used for infections and there are wound care plans in place to show how wounds are treated with regular updates shown. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	<p>FA</p>	<p>Partial provisional: There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation.</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Material safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>There was protective clothing and equipment in the sluice room and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a good understanding of processes relating to the management of waste and hazardous substances. A second sluice room which was created two years ago and is currently not in use, will form part of the psychogeriatric unit.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>There is a maintenance programme that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Current electrical safety tags on electrical items were sighted. Documentation and observations evidenced a current Building Warrant of Fitness. A code compliance certificate for the new building has not yet been provided to the owner.</p> <p>Observation of the facility and interview of the owner evidenced other rooms have been or are to be created from five existing bedrooms throughout the facility, over the past two years. Two bedrooms are now a second lounge for the psychogeriatric unit. One bedroom is now a toilet, an existing bedroom is to be turned into an activities room and hair dressers room, and one bedroom is now part of one of the two entrances into the new wing. Overall, there will be an increase of three beds and the total number of beds available will be 40. The owner also stated the family room will be turned into a nurse's station for the psychogeriatric unit.</p> <p>The owner advised they have not made application to HealthCERT for two bedrooms to be approved as dual purpose rooms. The two bedrooms are at the end of the passage way that divides the two units. New doors have been installed in the passage way on one side of the rooms and the doors on the other side are existing. The rooms are adequate for providing either dementia or psychogeriatric care.</p> <p>The bedrooms in the new building are large and the doors have one and a half leaves. Two of the bedrooms have ensuites.</p> <p>The doors in the existing building are single width, the openings are wide</p>

		<p>enough and rooms large enough to allow equipment and care staff to safely manage residents.</p> <p>Observations of the existing facility provided evidence of safe storage of equipment. Corridors are wide enough to allow residents to safely pass each other. Safety rails are secure and are appropriately located. The corridors in the new wing are wide with hand rails along all passageways.</p> <p>External areas are available and these are maintained to an adequate standard and are appropriate to the residents. Residents are protected from risks associated with being outside, including provision of adequate and appropriate seating and shade. Seats have been painted in bright colours and there are 'fiddle boards' for residents to enjoy. A new wooden fence has been erected dividing the external areas into two separate areas. There are appropriate handrails along the paths outside the new building to enable residents to safely mobilize.</p> <p>The two double external doors that open out from the main lounge in the new wing have latches to hold them open that are screwed into the concrete path. These are a safety hazard for residents. The owner removed these during the audit.</p> <p>There is a channel between the concrete path and the wall of the new wing situated outside the lounge area, that is not covered. This is a potential hazard for residents as they could fall into the gap.</p> <p>Care staff confirmed they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.</p> <p>Residents confirmed they know the processes to follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents and families confirmed they can move freely around the facility and that the accommodation meets their needs.</p>
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	Partial provisional: There are adequate numbers of bathrooms and toilets throughout the existing facility. Two of the bedrooms in the new wing have an ensuite which consists of a toilet and wash hand basin. All bedrooms have a wash hand basin. There is a large bathroom in the new wing that includes a shower and has been designed so that a bed bath can easily be used if required. The toilet can be isolated from the shower room if the shower is in

		<p>use. Residents and families reported that there are sufficient toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</p>
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	<p>Partial provisional: There is adequate personal space provided for residents and staff to move around within the bedrooms safely. Residents and families spoke positively about their or their relative's accommodation. Rooms are personalised with furnishings, photos and other personal adornments. Personal space for residents in the new wing is more than adequate. Rooms are large with lots of room for residents and staff to move about in.</p> <p>There is room to store mobility aids as needed. The new wing includes two new storage areas.</p>
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	<p>Partial provisional: There are several areas in the existing facility for residents to frequent for activities, dining, relaxing and for privacy. Residents, family and staff confirmed these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The new building has a large lounge area and there are areas in the existing part of the facility for dinning and another lounge that will form part of the psychogeriatric unit.</p>
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	<p>Partial provisional: All laundry is washed on site. Residents and family reported the laundry is managed well and resident's clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site who have received appropriate education. A cleaner confirmed this. Chemicals are stored in the laundry securely. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>

<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Partial provisional: There is an approved fire evacuation plan. The FM and owner advised a new application has been submitted to the NZ Fire Service for the approval of the fire evacuation plan that includes the new building. The owner advised they have not yet received a letter from NZ Fire Service approving the scheme. There is an evacuation policy on emergency and security situations that covers service groups at the facility. A fire drill takes place six-monthly and was last held 10 November 2016. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. Required fire equipment was sighted and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs.</p> <p>There are call bells in all resident areas in the existing facility. A call bell system has been installed in the new building that is linked to the existing system. Observation during the audit showed there is no call bell situated in the lounge of the new building.</p> <p>Contractors must sign in and out of the facility. The external doors are on a timer and automatically lock in the evenings.</p>
<p><b>Standard 1.4.8: Natural Light, Ventilation, And Heating</b></p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Partial provisional: Heating is provided by ducted ceiling outlets in the existing facility. Heating in the new building is provided by under floor heating with individual thermostats in each room. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable.</p>
<p><b>Standard 3.1: Infection control management</b></p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from infection control policies and procedures. The</p>

<p>shall be appropriate to the size and scope of the service.</p>		<p>infection control programme and manual are reviewed annually in September.</p> <p>A registered nurse is the designated IPC officer, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly at quality meetings and to senior management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> <p>No additional actions would be required to the infection control programme if an increase in bed numbers occurs.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC officer reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, at quality meetings and the owner/director is informed if any concerns arise.</p> <p>There have been no reportable outbreaks since the previous audit. In December, a spike in chest infections was recorded. These were explainable owing to a 'flu bug'. This was shown on the corrective action plan put in place. Staff explained that owing to the type of residents they have it is very difficult to keep someone in their bedrooms to assist in the prevention of infections of this type.</p>

Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	There is currently one resident using restraint and no residents using an enabler. There has been a decrease in the use of restraint since the last surveillance audit. The restraint register confirmed this. A RN is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff were knowledgeable about restraints and enablers. The restraint coordinator also reported there is a dedicated caregiver rostered on in the main lounge area on the afternoon shift so that challenging behaviours are managed, and residents are kept occupied. During the audit, residents were calm and staff were observed to be interacting with residents in a patient manner.
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 policy and procedure has been reviewed and is now appropriate to the level of services provided at Sunhaven. A registered nurse is the designated restraint coordinator. Responsibilities of the restraint coordinator and approval group are clearly outlined. Restraints to be used for the resident are approved by the restraint approval group prior to commencing the restraint. The GP completes three-monthly review of the restraints in use.  Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes.
Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The new restraint assessment forms meet the requirements of the standard. Completed assessment forms prior to commencing any restraint were in the file of the resident using restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. The resident's care plan documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.
Standard 2.2.3: Safe Restraint Use  Services use restraint safely	FA	Safe use of restraint is actively promoted. There is a current and updated restraint register.

Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint.	FA	An evaluation form for restraint use has been developed and implemented that meets the requirements of the standard. The evaluation form included the effectiveness of the restraint and the risk management plans documented in the long-term care plans. The resident's file reviewed evidenced evaluation of restraint was completed three monthly. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use.

## 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is collected collated and analysed to identify trends. Staff interviewed and meeting minutes evidenced that data including analyse is reported back to staff. Although staff stated they discuss trends at their meetings, this was only briefly recorded in the minutes.	Meeting minutes do not record sufficient detail relating to discussion around trends following analysis of quality data.	Record in the meeting minutes, discussion around identified trends following analysis of quality data.  180 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,	PA Moderate	The documented medication management system identified in policy meets current good practice and legislative guidelines.  Dispensing, administration, review, storage, disposal and medicine reconciliation comply with best practice guidelines.  The prescribing of some medication does not meet legislative	Four of the ten medication charts reviewed did not have stop dates for short course medication.  There is no blood sugar range shown for when insulin should be withheld or at what level the GP wishes to be contacted.  One medication chart did not	Provide evidence that all aspects of medication management are consistent with relevant legislation, protocols and guidelines.  30 days

protocols, and guidelines.		<p>requirements as medications are not written in the correct part of the medication chart. For example, non-sachet medication is charted under the sachet medication section and regular medication is charted in pro re nata (PRN) medicines section and vice versa, one updated medication chart had no prescriber signature. Stop dates for short course medications are not consistently written.</p> <p>There was no guidance related to one insulin controlled diabetic resident, with unstable blood sugar level recordings, of when to withhold insulin or when the doctor wished to be notified.</p> <p>Although the facility has undertaken improvements to medication management, such as regular staff education and correct documentation in the controlled drug register, this area identified for improvement in the previous audit remains open. The facility is looking at introducing an electronic medication system, which the GP feels will correct most of the issues found during this audit.</p>	<p>have any prescribers signature (This was an updated medication chart and the old chart was not in the file).</p> <p>Four of the 10 medication charts reviewed had prescribed medication documented in the wrong part of the medication chart.</p>	
<p><b>Criterion 1.3.3.3</b></p> <p><b>Each stage of service provision (assessment, planning, provision, evaluation, review,</b></p>	PA Low	<p>Each stage of planning, provision of service, evaluation and review is provided within required time frames. The service only has one interRAI competent RN and one RN in</p>	<p>Three interRAI assessments are overdue. One was due in December 2016 and two were due in February 2017.</p>	<p>Ensure each stage of service provision is provided within time frames to meet contractual requirements.</p>

and exit) is provided within time frames that safely meet the needs of the consumer.		training there are three assessments overdue. A further three assessments are due in March 2017.		180 days
Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	Evaluation of residents' progress are clearly shown in progress reporting. The formal, six monthly care evaluations are undertaken, but often the finding is documented as an intervention and not an outcome. For example, evaluation of a resident with assessed poor skin integrity states 'maintain two hourly turns'. There is no indication if the interventions being undertaken have kept the resident's skin intact.	Evaluation in three of the seven residents' files reviewed, do not indicate the degree of achievement or response to the interventions shown on the care plan.	Provide evidence that evaluations indicate the resident's response to planned interventions.  90 days
Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation.	PA Low	A current building warrant of fitness is displayed. There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Testing and tagging of electrical equipment is current.  A code compliance certificate has not yet been supplied for the new wing. The owner advised they are waiting for the final inspection and that this should be provided in the next week or so.	A code compliance certificate has not yet been issued for the new building.	Provide evidence of a code compliance certificate for the new building.  Prior to occupancy days

<p><b>Criterion 1.4.2.4</b></p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The existing facility has bedrooms of varying sizes and are large enough for residents to mobilize within. Passage ways are wide enough with handrails to allow safe mobility. Passage ways in the new wing are wide and there are handrails throughout. Doors to the bedrooms are one and a half leaves and the rooms are large. Secure areas are appropriate to the service groups and these have been separated by erecting a wooden fence. The new wing has safety rails along the paths and there is seating.</p> <p>The owner stated that two bedrooms situated between the two units will be dual purpose beds. The owner advised they have not made application to HealthCERT regarding this. Observation showed the two bedrooms are situated on either side of the passage way at the end that divides the two units. New doors have been installed in the passage way on one side of the rooms and the doors on the other side are existing. The rooms are big enough and adequate for providing either dementia or psychogeriatric care. The owner was advised by the auditor, should the rooms be approved by the HealthCERT, both rooms would need to be occupied by residents who require one service or the other and not one resident from each service.</p>	<p>(i)The owner is planning to use two bedrooms situated at the end of the passageway dividing the two units. The owner has not applied to HealthCERT for these rooms to be approved for use as dual purpose. (ii) The rain water channel outside the main lounge in the new building is not fully covered.</p>	<p>(i)Make application to HealthCERT for two bedrooms to be approved as dual purpose rooms. (The owner made application to HealthCERT as required in early April, as required. ) (ii) Provide evidence that the channel for carrying rain water situated outside the main lounge of the new building is covered with appropriate material, for example appropriate grating.</p> <p>Prior to occupancy days</p>
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		<p>There is a channel for carrying rain water that is approximately 150mm wide and 100mm deep between the concrete path and the wall of the new wing situated outside the lounge area. The area is covered where the external doors are situated, however the rest of the channel is open. This is unsafe and has the potential for residents to fall into the gap.</p>		
<p>Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>There is a fire evacuation scheme that was approved 6 November 1995. The FM and owner advised a new application has been submitted to the NZ Fire Service for the approval of a new fire evacuation plan that includes the new building. The owner advised they have not yet received a letter from NZ Fire Service approving the scheme.</p>	<p>An application has been submitted to the NZ Fire Service for approval of a new fire evacuation plan that includes the new building.</p>	<p>Provide documented evidence from NZ Fire Service that the new fire evacuation scheme is approved.  Prior to occupancy days</p>
<p>Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	<p>There are call bells to alert staff in all resident areas in the existing facility. Residents and families reported staff respond promptly to call bells. A call bell system has been installed in the new building that is linked to the existing system. Observation during the audit evidenced there is not a call bell situated in the lounge of the new building. During the audit, the owner contacted the appropriate contractor to try and find where the wiring for the call bell was. The</p>	<p>There is no call bell situated in the lounge of the new building.</p>	<p>Provide evidence that a call bell has been installed in the lounge of the new building.  Prior to occupancy days</p>

		owner stated it appeared the place where the call bell should be, has been plastered over.		
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## **Specific results for criterion where a continuous improvement has been recorded**

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

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

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

No data to display

End of the report.