

# Sunrise Healthcare Limited - Jervois Residential Care

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## Introduction

This report records the results of a Provisional 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](#).

The specifics of this audit included:

**Legal entity:** Sunrise Healthcare Limited

**Premises audited:** Jervois Residential Care

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

**Dates of audit:** Start date: 5 July 2017 End date: 6 July 2017

**Proposed changes to current services (if any):** A provisional audit was conducted to assess a prospective new owner for the facility and to assess the current status of the service prior to purchase.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 37

# 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

## General overview of the audit

Jervois residential care is part of the TerraNova homes. The service currently provides care for up to 46 residents. The service is certified to provide hospital (medical, geriatric) and rest home level care. On the day of the audit, there were 37 residents.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with a GP, residents, family members, staff and management. The prospective owner was interviewed on the first day of the audit.

The prospective provider owns a 40-bed hospital in Auckland. The prospective provider intends to continue with the quality processes as set out in the previous provider's quality plan. The current facility manager and the Terra Nova clinical quality and risk advisor will provide orientation and induction to processes and the clinical coordinator will stay on in charge of the clinical services. The prospective provider (chief executive officer) is a qualified chartered accountant and will oversee financial matters. Reporting processes will stay in place but reports will be to the new directors. The prospective providers' transition plan is to keep all

operational processes the same with only the directors changing. The current owners have entered into contractual arrangements where they will provide Vendor Support for 20 working days following completion of the sale and provide core system services for up to 6 months from completion (as needed) to allow an ordered transition of these services.

The facility manager (RN) has many years' experience in aged care management. The clinical coordinator (RN) has been in the role for sixteen months.

## **Consumer rights**

Consumer rights

## **Organisational management**

Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager and clinical coordinator are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Jervois residential care is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality corrective action forms/education, demonstrate a culture of quality improvements.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, seven days a week.

## **Continuum of service delivery**

There is a comprehensive admission package. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Staff that are responsible for the administration of medicines complete annual education and medication competencies. The medicine charts reviewed were reviewed at least three-monthly.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. The programme runs over five days each week. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences.

All meals and baking are done on site. Residents' food preferences, dietary and cultural requirements are identified at admission and in an ongoing manner and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## **Safe and appropriate environment**

The building holds a current warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. There is safe access to the communal areas and outdoor seating and shade. Resident bedrooms are personalised. There are adequate communal shower/toilet facilities. Documented policies and procedures for the cleaning services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Laundry service is completed by an external provider.

A civil defence/emergency plan is documented for the service. There is a staff member on duty at all times with a current first aid certificate.

The building holds a current warrant of fitness. All rooms are single with hand basins, are personalised and spacious. Communal areas are easily accessed and there is adequate room for residents to move freely about the home using mobility aids. Communal areas are well utilised for group and individual activity. The internal areas are able to be ventilated and heated. The outdoor areas are safe, well maintained and accessible.

There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. Electrical equipment is tested and tagged. Chemicals are stored securely throughout the facility. Laundry services (provided off-site) are well monitored through the internal auditing system. The cleaning service maintains a tidy, clean environment. There is an approved evacuation scheme and staff are trained in emergency management procedures. There is water, food and equipment stored for use in an emergency. A first aider is on duty at all times.

## **Restraint minimisation and safe practice**

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint steering group meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers. On the day of audit, the service had no residents requiring restraint and no enablers.

## **Infection prevention and control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control resource nurse (clinical coordinator) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control resource nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the

facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking of infections with an external provider. Staff receive ongoing training in infection control.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (four caregivers, two registered nurses, facility manager, clinical coordinator, diversional therapist), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are procedures in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Policies include informed consent policy, advocacy policy and guidelines for resuscitation.</p> <p>There were signed general consents including outings and resuscitation status in all seven resident files sampled (four hospital including one young person with disability and three rest home</p>

		<p>residents including one respite). Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed.</p> <p>Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.</p> <p>Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>Informed consent processes and family/resident care plan updates are also reviewed through the six-monthly care plan evaluations and multidisciplinary reviews.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Contact numbers for advocacy services are included in the policy, the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly. The service encourages their YPD resident to have continued involvement with community groups. The service has a van that is used for outings. Many of the hospital residents have high physical needs, so often it is more appropriate to support family, friends and community groups to come into the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of all complaints, both verbal and written, by using a complaint register. Complaints are documented on the organisation's electronic system (People Point). These are also able to be monitored by head office.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility. Six complaints received in</p>

		2016/2017 YTD were reviewed, with evidence of appropriate follow-up actions taken. There were no outstanding complaints. All complaints reviewed evidenced resolution to the complainants' satisfaction.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The facility manager, the clinical coordinator and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All six residents (three rest home level, two hospital level and one YPD) and two relatives (one rest home, one hospital) interviewed, report that the residents' rights are being upheld by the service. Staff interviewed were familiar with the Code of Rights Standard Operating Procedure (SOP).</p> <p>The prospective buyer owns an aged care facility in Auckland and has a good understanding of consumer rights.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend other churches if they wish. Residents interviewed reported that they can choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education around this has occurred.</p> <p>The facility has seven double/shared rooms. One was vacant and two had single occupancy on the day of audit. Privacy curtains were observed in each room to maintain resident's privacy and dignity. Residents and or family/whānau are informed of the availability of rooms on enquiry and whether they are single occupancy or shared occupancy.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	<p>The service has a Māori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. There were no residents that identified as Māori. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. The service link with the whānau and iwi</p>

		of Māori residents and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff have had training around cultural safety.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains an individual, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all six care plans reviewed (two rest home level, and four hospital level). Residents and family/whānau interviewed confirmed they were involved in developing the residents plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service promotes evidence-based practice and encourages good practice. Registered nursing staff are available 24 hours a day. A house GP visits the facility one day a week. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits. Physiotherapy services are provided on site, four hours per week with the support of a physiotherapy assistant three hours a day. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents</p>

		<p>to remain independent.</p> <p>The 2017 education sessions are being delivered as planned. Education sessions include opportunistic education identified by clinical coordinator and facility manager that require extra training.</p> <p>TerraNova has established benchmarking across its sites. There is a strong commitment to quality improvement at Jervois and across the organisation. Improvement initiatives and quality goals are identified involving staff and are regularly reviewed. Steering groups for restraint, infection control and H&amp;S are being implemented at an organisational level.</p> <p>Risk management reports are completed for residents at risk and service delivery risks such as (but not limited to) incidents/accidents, residents with pain, unexplained weight loss, identified depression. Action plans are implemented to minimise the risk and processes reviewed and evaluated. A management report is provided to head office and discussed, and shared through manager teleconferences.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Standard operating procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed on (people point) reflected documented evidence of families being informed following an adverse event unless the (cognitively aware) resident chooses to notify family themselves. This information was documented on the accident/incident forms. Progress notes also identify family/whānau being kept informed.</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>Jervois residential care is part of the TerraNova homes. The service currently provides care for up to 46 residents. The service is certified to provide hospital (medical, geriatric) and rest home level care. On the day of the audit, there were 37 residents. There were 25 hospital residents (24 under the ARCC agreement and one YPD). There were 12 rest home residents [including one respite]. All resident rooms are dual-purpose. There are seven double/shared rooms. One double room was currently vacant and two had single occupancy.</p> <p>The organisation has a vision, mission statement and objectives. There is an organisational business plan that links to the site-specific quality goals and objectives. Annual goals for the facility have been determined, which link to the overarching organisational plan. Quality goals for 2017 include: (i) The reduction of restraints by 65% based on 2016 figures. (ii) Reduce the rate of infections by 50% based on 2016 data. (iii) 90% of newly employed staff will have completed L2 certificate in Health &amp; Wellbeing within 90 days of start date by end of December 2017. (iv) Increase staff attendance at training by 50%. Progress to meeting goals are regularly reviewed through meeting minutes.</p> <p>The managers across TerraNova teleconference weekly as a group with the CEO. One of the key focuses of the organisation is transparency and learning. Weekly teleconferences between managers and clinical managers, provides that opportunity. A monthly risk management report is completed at Jervois; review/outcome is completed as part of that report and monitored by head office.</p> <p>The facility manager (RN) has also been managing Jervois home for the last 7 months and divides her time between the West Harbour and Jervois.</p> <p>The clinical coordinator (RN) has been in the role for sixteen months and has worked in aged care prior to this appointment. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The facility manager and clinical coordinator have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
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		<p>The prospective provider owns a 40-bed hospital in Auckland. At the provisional audit, the auditor established that the prospective provider intends to continue with the quality processes as set out in the previous provider's quality plan. The current facility manager and the TerraNova clinical quality and risk advisor will provide orientation and induction to processes. The current facility manager will continue in the role and the clinical coordinator will stay on in charge of the clinical services. The prospective provider (chief executive officer) is a qualified chartered accountant and will oversee financial matters. Reporting processes will stay in place but reports will be to the new directors. The prospective providers' transition plan is to keep all operational processes the same with only the directors changing. The current owners have entered into contractual arrangements where they will provide Vendor Support for 20 working days following completion of the sale and provide core system services for up to 6 months from completion (as needed) to allow an ordered transition of these services.</p> <p>The prospective purchaser advises that there are no plans to make any changes to the facility. Proactive and reactive maintenance will be maintained as per current plan.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>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.</p>	FA	<p>A clinical coordinator/registered nurse (RN) who is employed full time, supports the facility manager, and steps in when the facility manager is absent. The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life. The prospective provider will assist the clinical coordinator in the absence of the facility manager.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems.</p> <p>TerraNova's policies, procedures and relevant forms are available both in hard copy and online under "Share Point" (intranet). Review of clinical policy, procedure etc. is coordinated by the Clinical Quality and Risk Advisor (CQRA) in conjunction with the Facility Managers and Clinical coordinators. Approval of the amended/new document</p>

	<p>involves the executive management team before uploading and release of the document.</p> <p>Updated documents are released/supplied to the facility. A memo is sent to the managers along with printed copies of relevant documents for filing in their master hard copy folders. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place.</p> <p>TerraNova has robust quality and risk management systems implemented across its facilities. Across TerraNova, benchmarking is well established. A recent online 'ZAP reporting' system has been set up which pulls data/clinical indicators from People Point (electronic system). This gives a more thorough analysis and is monitored by the TerraNova Clinical Quality &amp; Risk advisor who supports the managers at Jervois to further analyse the data and introduce corrective actions where needed.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure injuries, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>A residents meeting occurs monthly and an annual resident survey is completed. The recent 2017 survey identified overall satisfaction with the service evidencing a similar result as previous year.</p> <p>Interviews with staff and review of meeting minutes/quality corrective action forms/opportunist education sessions, demonstrate a culture of quality improvements.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. H&amp;S is an agenda item of the staff meeting. Hazard identification forms and a hazard register are in place (link 1.4.2.4).</p>
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		<p>Health and Safety management has been improved with organisational three-monthly H&amp;S meetings, the appointment of a H&amp;S Officer and Rep and a focus on reducing hazards and promoting safe work habits amongst employees.</p> <p>Three steering groups at an organisational level have been implemented including a restraint, H&amp;S and infection control group. A representative from Jervois attends each of the organisational steering groups.</p> <p>A robust risk management system is in place with the clinical coordinator completing a monthly risk management report with corrective actions. Incident management is well managed, with all incidents being reported on 'people point' and reviewed by the clinical coordinator and facility manager (FM) daily. Incidents are also able to be reviewed in detail by the CEO and CQ&amp;R advisor on 'people point'.</p> <p>The prospective provider will be taking over the current policies of the service and continue to use the policies for guiding service provision, this includes the current skill mix policy.</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>	<p>FA</p>	<p>Ten accident/incident forms were reviewed (from June 2017). Accident/incident forms and electronic records of incidents (on People Point) identify follow-up by a RN. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incidents are benchmarked and analysed for trends. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes.</p> <p>The facility manager was aware of the requirement to notify relevant authorities in relation to essential notifications. The facility manager was able to provide copies of Section 31 notifications to the Ministry of Health with regards to pressure injuries.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (FM, CM, RN, two caregivers, one activity coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.</p>

		<p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are buddied for a period of time and during this period they do not carry a clinical load. The orientation booklet aligns with NZQA foundations level two and they have 90 days to complete. On completion of this orientation, the staff member has attained their first national certificate. From this, they are then able to continue with Core Competencies Level 3 unit standards.</p> <p>The 2017 education planner is implemented. Education sessions are being delivered as planned to include opportunistic education around areas of development identified by CC and FM that require extra training. Education and training for clinical staff is linked to external education provided by the district health board. The service has well exceeded over 8 hours of training provided annually.</p> <p>A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Competencies include (but not limited to) cultural, glucose monitoring &amp; insulin, fire safety, medication, manual handling, controlled drug checking, restraint SC administration, infection control, wound care and compression bandaging.</p> <p>Three of five registered nurses have attained InterRAI competency.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The facility manager is responsible for the management of Jervois residential care and another TerraNova site West Harbour Gardens. The prospective purchaser is planning to purchase Jervois Residential Care and West Harbour Gardens with the current facility manager spending three days at West Harbour Gardens and two days at Jervois Residential Care. The clinical coordinator works Monday-Friday and shares on call out of hours with the facility manager and the clinical coordinator at West Harbour Residential Care.</p> <p>On the day of audit there were 37 residents.</p>

		<p>Registered nurses work 12-hour shifts. There is registered nurse cover provided 24/7, seven days per week.</p> <p>There are four caregivers (working varying hours) on duty on the morning and afternoon shift, there are two caregivers on night duty.</p> <p>The prospective provider has had time to complete a thorough investigation into current staffing needs. The prospective provider will be taking over the current policies of the service and continue to use the policies for guiding service provision, this includes the current skill mix policy. Plans are in place to keep the mix and quality of staff the same as that currently in place.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. All staff have access to areas relevant to them on the People Point electronic system. Electronic records are protected from unauthorised access. Hard copy records are held securely.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. Electronic records clearly identify staff member and time.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs including information on the services are provided for resident and families. Admission agreements for long-term residents aligned with contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The procedures include a transfer/discharge form and 'the yellow envelope' is used and copies of all required information are</p>

		added to the envelope.
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. RNs who administer medications have been assessed for competency on an annual basis. Caregivers who act as second checker had a medication competency. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication folders include a list of specimen signatures and competencies. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored weekly. There were two residents self-medicating on the day of audit. Self-medicine competencies for those residents had been completed. There is a signed agreement with the pharmacy.</p> <p>Fourteen medication charts reviewed met legislative prescribing requirements. The GP has reviewed the medication charts three-monthly. Administration records demonstrated medications are signed as administered. The internal audit programme includes medication audits.</p> <p>Policies for controlled medications document a safe practice that includes two medication competent staff signing for medications, one being a registered nurse when a registered nurse is on duty.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The kitchen manager has been with the service twenty years and works full time. There is a second cook and three kitchenhands covering a seven-day week service. All meals at Jervois are prepared and cooked on site by the kitchen manager/cook. On the day of audit, meals were observed to be hot and well presented. The meal is served from a bain marie in one dining room and an electric warmer in the other. Stock is rotated and stored correctly. The kitchen was observed to be spotlessly clean on the day of audit. Fridge and freezer temperatures are monitored twice daily. End cooked temperatures are monitored daily. There are policies in place to guide staff. Chemicals are stored safely within the kitchen.</p> <p>There is a four-weekly seasonal menu which had been reviewed by a dietitian in November 2016. The residents have a nutritional profile developed on admission which identifies dietary requirements,</p>

		<p>allergies and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff.</p> <p>Resident meetings along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six-monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented and all residents have an up-to-date completed InterRAI assessment in their clinical file. Care plans sampled were developed on the basis of these assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident files reviewed were resident focused and individualised. Identified support needs as assessed were included in the care plans for all resident's files. Files sampled included individualised preferences relating to personal hygiene needs including shower times and days. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as the physiotherapist and mental health services. Short-term care plans were in place for short-term needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families were documented in the resident's progress notes.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Initial wound assessments and ongoing evaluations were in place for one resident with a surgical wound. There was a range of equipment readily available to minimise pressure injury. There is access to a wound nurse specialist at the DHB as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health such as infections.</p> <p>Monitoring forms are used, for example, observations, behaviour, blood sugar levels and neurological signs.</p> <p>Care plans documented residents' current 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>	<p>FA</p>	<p>There is a diversional therapist (DT) who currently works two days per week and an activities assistant (AA) who works the other three days per week. The activities programme is developed monthly and displayed in large print on the residents' noticeboard and given to residents and families. The activities programme meets group and individual preferences of the resident group. Activities take place in the main lounge and one-on-one activities are provided for residents who are unable to participate in group activities. The programme is varied and interesting with exercises, reading current news and stories, crafts and pampering. There are weekly van outings with visits to Auckland sites of interest. Links with the community involve visiting kindergartens, music entertainers (a music therapist visits and there are two residents who play piano, one with dementia who was observed playing the piano at time of audit) and church services.</p> <p>A social history and activity plan is completed on admission in</p>

		consultation with the resident/family (as appropriate) and reviewed at least six-monthly. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. Those residents who prefer to stay in their room have daily visits from either the DT or the AA. The YPD resident likes to join in activities, especially the exercise group and also goes out with social worker and family at least three times a week.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by an RN. In all long-term resident files sampled the long-term care plans had been reviewed at least six monthly or earlier for any health changes. Progress toward goals was documented in all files sampled. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.  Files reviewed demonstrated that short-term needs were documented on short-term care plans which were regularly evaluated. Short-term care plans were evidenced to be signed off once completed or transferred to the LTCP as required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services was evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the clinical coordinator and registered nurse identified that the service has access to a wide range of support either through the GP, DHB specialists and or contracted allied services.  The YPD resident was assisted to access community groups and health services as needed. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place. Safety datasheets and product sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in a locked chemical cupboard. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.

		Used linen is appropriately managed and all laundry is managed offsite. Staff interviewed (housekeeping staff, caregivers) were knowledgeable about chemical safety.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained.</p> <p>Monthly inspections include call bell testing, monthly fire checks and hot water temperature monitoring. Hot water temperature recordings reviewed were below 45 degrees Celsius. Electrical testing and tagging was current and annual calibration of medical equipment had been completed by an external contractor.</p> <p>The facility has corridors with sufficient space for residents to safely mobilise using mobility aids.</p> <p>There is safe access to outdoor areas. Seating and shade is provided.</p> <p>The RN and caregivers interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including hoists and pressure injury prevention equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of communal toilet and shower facilities for each wing. The toilets and showers are of an appropriate design to meet the needs of the residents. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are thirty-two single rooms and seven double rooms in total. There are three wings (Kauri with fourteen single beds, Nikau with fourteen beds including three double rooms and Kowhai with seventeen beds including four double rooms) all on the same floor. One double room was vacant during the audit, one was occupied by two sisters, three had two residents occupying, two double rooms had one resident with one bed vacant in each. Privacy curtains were in place. Residents and families are encouraged to personalise their rooms. Bedrooms viewed were personalised.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a large main lounge, two dining rooms and smaller lounges for small groups and one-on-one activities. Seating and space in the main lounge is arranged to allow both individual and group activities to occur. The communal areas are easily accessible for residents or with staff assistance.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures for the safe and efficient cleaning services. There are dedicated cleaning staff five days a week who fully implement cleaning schedules. All linen and personal clothing is laundered off-site. Internal audits monitor the effectiveness of the cleaning and laundry processes. The cleaner's trolley is kept in designated locked areas when not in use. Personal protective equipment is readily available.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A civil defence/emergency plan is documented for the service. The New Zealand Fire Service approved the fire evacuation scheme on the 18 October 1999. Fire drills occur every six months (last fire drill occurred in April 2017). Emergency management training occurs as part of orientation for new staff. Staff interviewed confirmed their understanding of emergency procedures. There are adequate supplies available in the event of a civil defence emergency of food, water and blankets. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. Staff conduct security checks in the evenings to ensure the facility is secure.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</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>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a comfortable temperature within bedrooms and communal areas. There are sufficient doors and opening windows for ventilation. All bedrooms have windows, which allow for plenty of natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall</p>	FA	<p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises</p>

<p>be appropriate to the size and scope of the service.</p>		<p>and reporting. The clinical coordinator is the appointed infection control coordinator and she is responsible for infection control across the facility. The organisational IC steering group is responsible for the development of the infection control programme and its review. The facility review is also completed through the IC programme review internal audit. The infection control programme is well established at Jervois residential care. The infection control committee is incorporated as part of the staff meeting. There have been no outbreaks since the previous audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Jervois. The infection control (IC) coordinator has maintained best practice by keeping up-to-date with infection control updates. The IC coordinator has also completed IC training online through MOH. The infection control team is representative of the facility and is incorporated as part of the staff meeting. External resources and support are available through the HCPNZ, simple solutions and the TerraNova IC steering committee that meets bi-monthly. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a range of policies, standards (SOP) and guidelines, defines roles, responsibilities and oversight, surveillance, training and education of staff and scope of the programme. The policies and procedures are currently in the process of being updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held and has been completed in 2017.</p> <p>The infection control coordinator has received education both in-house and by an external provider to enhance her skills and knowledge. The</p>

		<p>infection control coordinator has access to the TerraNova IC steering group for resources, guidelines best practice and group benchmarking. Infection control is also a component of the wound care competencies completed by RNs. There is also an IC competency completed by all staff.</p> <p>A number of education talks have been provided at handover including (but not limited to) preventing UTIs, eye care and hand hygiene.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the TerraNova infection control manual.</p> <p>An individual resident infection form is completed (IC wizard on People Point). Monthly infection data is collected for all infections based on signs and symptoms of infection. These are reported into Simple Solutions benchmarking programme. An infection analysis summary is auto-populated. The IC coordinator has utilised these summaries to identify trends and reduce infections. Graphs, corrective actions and outcomes are shared with staff through meetings. There is an organisation IC steering group that meets bi-monthly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint/enabler management procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint steering meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had no residents requiring the use of a restraint or an enabler.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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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 of this audit.

No data to display
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End of the report.