# Bima Health Limited - Sunhaven Rest Home & Private Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bima Health Limited

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

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

**Dates of audit:** Start date: 31 August 2017 End date: 1 September 2017

**Proposed changes to current services (if any):** An eight-bed unit was certified as an extension of the psychogeriatric unit at the last surveillance audit. Due to the falling number of referrals for residents requiring psychogeriatric care, the Taranaki District Health Board and service have agreed that there is a need for the unit to now be for residents requiring residential disability-psychiatric care with the eight beds now converted to a non-secure unit. The unit is ready for occupancy if approved through this partial provisional audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Sunhaven Rest Home & Private Hospital (referred to as Sunhaven) can provide care for up to forty residents. There is a dementia unit and psychogeriatric unit already in place with separation of the two imminent. This audit is for certification of the dementia and psychogeriatric beds.

A partial provisional audit of the eight-bed unit designated previously for residents requiring psychogeriatric care was also undertaken to establish the level of preparedness for the service to change the use of this to a non-secure unit for residents requiring residential disability-psychiatric care. The unit is ready for occupancy if approved through this partial provisional audit.

The certification and partial provisional audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board.

The audit process included the review of policies and procedures; review of a sample or resident and staff files; observations, and interviews with family, management, staff, the owner, a clinical community nurse and a medical officer.

There are improvements required to the security of the psychogeriatric unit now separate from the unit for residents with residential disability – psychiatric care needs and to securing of privacy in the toilet for residents in the eight-bed unit.

A continuous improvement has been given to the education and training provided to staff.

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

Residents receive services in line with the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). The systems in place to promote choice and encouragement for residents to have independence. There is a documented Maori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents’ values and beliefs.

Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected, and upheld. An up-to-date complaints register is maintained. Consents are documented.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is an annual business plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The manager provides operational management with the owner and clinical coordinators providing oversight in specific areas of maintenance and clinical care.

There is an established quality and risk management system in place. There are a range of policies and associated procedures and forms in use to guide practice. Quality outcomes data is collected and analysed to improve service delivery. An internal audit schedule is implemented with outcomes used to improve service delivery. Adverse events are reported to management and external agencies.

The human resource management system is consistent with accepted practice. There is an annual training plan in place that includes mandatory training and training for staff. Staff are knowledgeable and skilled with family members and the general practitioner praising staff for the way in which challenging behaviour is managed in a dignified and respectful manner. There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in both units and potentially in the eight-bed unit for residents with psychiatric care needs.

Resident information is stored securely and resident information is accurately recorded and current.

## Continuum of service delivery

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

Registered nurses are responsible for the development of care plans with input from the staff; family representatives and other health professionals involved in the care of the resident. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident.

Planned activities are appropriate to the residents assessed needs and abilities. In interviews, family expressed satisfaction with the activities programme.

A medicines management system is in place and medicines are administered by staff with current medication competencies. All medicine charts are reviewed by the general practitioner every three months or whenever necessary according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## 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. |

All building and plant complies with legislation with a current building warrant of fitness and a Code of Compliance for the new eight-bed unit. The New Zealand Fire Service evacuation scheme has been reviewed to include the eight-bed unit. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. There are specifically identified indoor and outdoor areas for residents in the dementia, psychogeriatric and eight-bed unit. Essential emergency and security systems are in place with regular emergency drills and staff training completed.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a designated restraint coordinator and restraint committee. The use of restraint is minimised and there was one resident using bedrails on the day of audit. Enablers are not used. Any use of restraint use is assessed, approved, and monitored. Staff receive ongoing education around management of challenging behaviour. Policies and procedures on restraint and enabler use are current.

## Infection prevention and control

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

The infection control management systems are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed and reported during quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. The infection control coordinator has had input into the design of the residential disability – psychiatric unit and will include the unit in the role.

## 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** | 1 | 47 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 1 | 98 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place to ensure consumer rights are respected by staff. Staff receive education during orientation and ongoing training on resident rights is included in the staff annual training schedule. Staff interviewed are all able to articulate knowledge of the Health and Disability Commissioner’s Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirm they receive ongoing education on the Code. Visual observations during the audit and the review of clinical records and other documentation indicate that staff are respectful of residents and incorporate the principles of the Code into their practice. The service provides information on the Code to families and residents on admission. Family interviewed state that they believe residents receive services as per the Code.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff mostly use verbal consents as part of daily service provision. Staff demonstrate an understanding of informed consent processes. Relatives confirm that consent issues are discussed with the relatives and residents on admission. Appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed include documented written consent. Residents are not able to make an advanced directive when they enter the service as they are assessed as requiring care in a secure unit (dementia or psychogeriatric). Some files reviewed include a clinical indicated advance directive made by the general practitioner. The clinical coordinators state that an advance directive would be used if this had been completed prior to entry to the service when the resident had been deemed competent. Residents have not been interviewed as all are deemed not competent and requiring dementia or psychogeriatric level of care. Family or the enduring power of attorney sign their consent form.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff. Discussions with family identifies that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident’s family and chosen social networks. Communication records between staff and family are documented in the resident record.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | There are no set visiting hours and family report that they are encouraged to visit at any time. Family members state that they are supported and encouraged to take a family member out whenever possible with the resident helped to be ready for the activity prior to leaving. The service encourages the community to be a part of the residents’ lives in the service with visits from entertainers and there are at least weekly outings for residents in the van to areas of interest.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents (as able) and family. Family confirm that the management open door policy makes it easy to discuss concerns at any time.Training around the complaints policy and process is part of the staff orientation programme and ongoing education. The complaints register records the complaint, dates and actions taken. One complaint reviewed indicates that timeframes are met as per the policy. There are no outstanding complaints at the time of the audit and the manager confirms that there have been no complaints to external authorities since the last audit.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed in the facility including pamphlets available for family. Information around advocacy services and the Code is included in the admission information pack and described by the manager as being discussed with residents and relatives on admission.Relatives interviewed confirm that the Code, the advocacy service, and residents’ rights are explained on admission. They also state that they can discuss any concerns with the manager, clinical coordinators, or registered nurses at any time.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | PA Low | There are a range of policies and procedures in place to ensure residents are treated with respect.Staff endeavour to maximise residents’ independence by encouraging residents to actively engage in cares. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit. Relatives interviewed state that staff have a high regard for the dignity, privacy, and independence of residents. All family interviewed state that the way residents are treated is a highlight of the service with real values and emphasis on respect and dignity. There are quiet, low stimulus areas that provide privacy for residents in the dementia unit, the psychogeriatric unit and the residential disability – psychiatric unit. An improvement is required to the toilet area in the residential disability-psychiatric care unit prior to occupancy.There is no evidence of abuse or neglect. Policies and procedures are explained by staff with a description of how they would escalate any issues of abuse or neglect if these were identified. Staff, family, and the general practitioner interviewed confirmed that there was no evidence of abuse or neglect.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Maori residents. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection and participation.Staff interviewed confirm an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training. Staff interviewed described how they had asked residents and family who had identified as Māori, about the care they should and could provide for the resident. This includes speaking in te reo for residents who identify with this as their language of choice. Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whanau as appropriate, for residents who identify as Māori. Links have been made with the Māori community. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirm their understanding of cultural safety in relation to care. Family members interviewed confirm that values and beliefs are respected by staff.There are no residents who have English as a second language however staff describe using family to interpret for the resident and being able to access interpreting services if required. The staff emphasised a focus on using signs and body language to understand what residents are telling them as often residents are non-verbal. Staff also describe using simple language and giving simple choices for residents who have dementia or who find communication difficult.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrate an awareness of the importance of maintaining boundaries with residents. Relatives report that staff maintain appropriate professional boundaries, including the boundaries of the health care assistant role and responsibilities. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. These align with the health and disability services standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. Evidence based guidelines, treatment protocols, reference material and resources are available and utilised by staff. Clinical staff have access to the internet and external expertise at the District Health Board if they need to consult and/or gain further clinical knowledge or advice.The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery. Demonstrated competencies are recorded. Staff interviewed confirmed that the facility provides a learning and supportive environment. Consultation is also available with health professionals and specialists in the region and staff can describe how and when they can make contact. A review of resident files confirms that staff contact specialists and the general practitioner when required. The general practitioner interviewed confirms that staff escalate issues when identified in a timely manner. Family members interviewed confirm they are very happy and satisfied with the care provided to their relatives living in the secure unit. Residents and families interviewed expressed a high level of satisfaction with the care delivered.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service provider has policies covering communication, access to interpreters and maintains an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff. The incident and accident forms include an area to document if the relatives have been contacted. Open disclosure is practised and documented when family are contacted.Relatives interviewed confirm that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirm that they are advised if there is a change in their family member's health status. The general practitioner interviewed reported satisfaction with communication from staff. There is a policy around use of interpreters and access to interpreting services is documented. Staff can describe how they would access interpreting services if required. They also state that family are encouraged to interpret for their family member.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation has been privately owned by the current owner for seven years. The owner has an office on site and they maintain daily contact with the manager and clinical coordinators including knowledge of occupancy, risks and ongoing service delivery. The owner reviews the performance of the manager annually.The service has agreements in place with Taranaki District Health Board for the provision of aged residential care – dementia and psychogeriatric care (both secure units). There is an agreement also to provide care for residents identified as requiring residential disability – psychiatric care (an eight-bed non-secure unit). The eight-bed unit is ready to open following the outcome of this partial provisional audit that confirms that the unit will change from offering psychogeriatric beds to being a residential disability – psychiatric unit (refer 1.4). This will also allow for the separation of the dementia and psychogeriatric units into two distinct units. A letter from the Taranaki District Health Board (7 October 2011) confirms that the District Health Board had agreed to a five-year timeframe for the completion of the separation. There are 40 beds in the whole service. Nine beds are identified as being for residents with dementia; 23 as being for residents requiring psychogeriatric care and eight for residents requiring residential disability – psychiatric care (subject to this partial provisional audit). On the days of the audit, there were 25 residents including eight requiring dementia level care and 17 requiring psychogeriatric care. The eight-bed unit is not open at this point. The purpose, values, priorities and goals are documented in the annual business plan. Key performance indicators are documented and monitored annually. These goals are then included in the quality and risk management programme. The manager has been in the role for over 10 years and has a bachelor of commerce degree. They have maintained training in management annually and are responsible for ensuring services are planned, coordinated and appropriate to meet the needs of the residents. The manager has completed training in dementia and challenging behaviour. There are two clinical coordinators (registered nurses) who provide clinical oversight. One has had over 30 years in working in aged care with 11 years in the service. The other has been in the service as a registered nurse since 2013 and has been in the role as a clinical coordinator for two years. Both clinical coordinators have competed at least eight hours of education in the last year to maintain their practising certificates. One clinical coordinator has completed training and has experience in working in mental health services and will be able to provide oversight of the residential disability – psychiatric unit. There are also three other registered nurses who have completed training in mental health who will be able to provide support for the residents. They also have varying degrees of experience working in mental health facilities. There are no changes to the management structure expected for the residential disability – psychiatric unit.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | The owner provides operational management in the temporary absence of the manager. They have a long history of owning rest homes including other dementia units in the past and are on site daily. The clinical coordinators are available and experienced to cover the service. Once the eight-bed residential disability – psychiatric unit is opened, there will be three nurses able to provide support in the event of the clinical coordinator with mental health experience being on leave. There are no changes to the delegation of the second in charge role expected for the residential disability – psychiatric unit. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management programme identifies objectives for the service. Activities within the programme are closely linked with health and safety, adverse event reporting, the infection prevention and control programme, restraint minimisation, and the resident complaints process. Quality related data and outcomes are collated, analysed and shared with staff at regular staff and continuous quality improvement meetings. There is a process implemented to measure achievement against the quality and risk management plan. Policies are reviewed two yearly of more frequently as required with these currently being fully reviewed. Policies sighted reflect current good practice, legislation and compliance requirements with policies current. Policies are also being updated to reflect any changes expected for residents in the residential disability – psychiatric unit. Currently the transition plan includes documentation of key differences. The contract is just being provided to the service by the District Health Board and this will also allow for the updating of any further policies. All documents sampled are controlled and obsolete documents removed from circulation. Policies and procedures and the internal audit schedule include reference to interRAI and care planning processes. A new archive storage unit for obsolete files has been built and is a locked area. There are a number of meetings to communicate information. These include meetings for registered nurses; continuous quality improvement; staff and management with these occurring at least two to three monthly depending on the schedule. Any issues identified through the meetings are signed off when resolved or action has been taken. The internal audit schedule is documented annually. Internal audits are planned and corrective actions are documented and implemented where a variance is identified. Corrective actions are discussed at both management, continuous quality improvement and staff meetings. There is documentation of resolution of issues. Trends are reviewed to improve service delivery with documentation of how this has improved service delivery. A risk management plan is documented. The risk register is maintained with evidence that any risks identified are proactively recorded on the register. Risks are also reviewed at regular intervals. Health and safety requirements are being met, including hazard identification. Health and safety is also maintained through checks of the premises each month. The safety checklist covers the entire facility and corrective actions if any are put in place. Daily hazards if any are written on the board, so all staff are aware of it and these are stated as being actioned quickly. Health and safety systems have been reviewed since the introduction of the Health and Safety at Work Act 2015. Staff can describe their roles and responsibilities in terms of reporting any risks including hazards. Training for staff around health and safety was last provided in 2017. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported. The manager and clinical coordinators can describe reporting of serious incidents including a section 31 completed for any pressure injury identified as grade three or above if required. There has not been any requirement to notify an external authority of any incident since the last audit. The incident forms that have been completed show evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner when incidents occur. Both family and the general practitioner interviewed confirm that incidents are reported in a timely manner. The review confirmed that documented incidents and accidents are closed following review by the clinical coordinator/s or manager and linked to the quality system. Monthly statistics on all documented adverse events are collated, analysed and reported at nurse meetings, continuous quality improvement meetings and through staff meetings. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | CI | There is an established system in place for human resource management.All staff records reviewed include an employment agreement and a position description. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education. A training plan is documented and implemented annually with at least monthly training sessions offered. Performance appraisals are completed for all staff who have been employed for 12 months or more and this ensures that any individual training needs are identified. There is a registered nurse in charge on each shift. Files of registered nurses reviewed hold current first aid certificates with all registered nurses having completed training through the District Health Board relevant to their role. Four registered nurses are interRAI trained with a further one registered nurse enrolled to complete interRAI training in September 2017. Medicines are given by registered nurses and healthcare assistants who have been assessed as competent. All staff are required to have completed dementia training. Two are currently enrolled and two new staff (employed less than three months) will be enrolled once orientation is completed. There are registered nurses already employed in the service who are trained in mental health who are expected to lead and provide oversight of the residential disability – psychiatric unit. The service has already identified the need to arrange workshops/training sessions from Taranaki District Health Board Mental Health Services specific to the needs of the older person with mental health conditions and a discussion with the funder confirmed that the training will be available. The service has identified that the training will specifically emphasize support and care of people with chronic health conditions needs; rehabilitation/habilitation concepts, promotion of independence and recognition of individuality; communication, including sensory and cognitive loss and other barriers to communication, communication aids and practical care skills. The service is to be commended for the training put in place that has led to implementation of best and evidence based practice particularly in relation to management of challenging behaviour.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The process for determining provider levels and skill mix is defined in policy and takes into account the layout of the facility and levels of care provided. Staff rosters are developed by the clinical coordinators and manager. Rosters and staff interviewed and observation on the days of audit confirmed there are sufficient numbers of staff in each area to meet minimum requirements as specified in the Aged Residential Care Agreement. Casual staff are available to pick up extra shifts when staff rostered are on leave with a review of rosters confirming that staff are replaced if absent. There is a staff member on duty with a current first aid certificate on each shift. The facility requires that all registered nurses and some health care assistants hold valid first aid certificates and copies are in place on staff files. 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. There is an RN rostered on all shifts. There are four health care assistants in the secure unit morning and afternoon and one health care assistants overnight. One of the health care assistants stays in the main lounge at all times, with an extra health care assistant who ‘specials’ a resident if required. Staff state that they can call for assistance after hours with the manager and owner available at all times. Staff state that in the past when they have rung, there has been an immediate response. The manager reported the roster is reviewed constantly. 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.The dementia unit and psychogeriatric units are to be separated into two units after this audit. Staffing will be as follows: a) two health care assistants on morning and afternoon shift and one overnight in the dementia unit with 10 hours registered nurse hours allocated to the unit; b) three health care assistants on the morning and afternoon shift with one being a short shift and one health care assistants overnight with a registered nurse on each shift in the psychogeriatric unit; c) a registered nurse and one health care assistants on the morning shift, two health care assistants in the afternoon and one at night each day seven days a week in the eight-bed unit for residents requiring disability – psychiatric support. The registered nurse in the unit will have completed mental health training.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Electronic and paper-based clinical records are maintained for each resident. All records are maintained confidentially. The resident records are stored in a locked cupboard in the nurse`s station. The detail is adequate and records information important for ongoing care and support being provided. A record of past and present residents is maintained electronically. InterRAI assessments are completed by the registered nurses and inform the development of the resident plan of care. Progress records are clearly documented by the clinical staff in the paper-based record. The date, time, signatures and designation of those entering into the records is legible.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to service policy includes all the required aspects on the management of enquiries and entry. The service has a welcome pack that contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family and where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements are completed and signed within the required time frames on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family interviewed confirm that they receive sufficient information regarding the services to be provided.There is a document provided to any new residents and families entering the service or to those interested that describes the dementia and psychogeriatric service provided. This includes philosophy, the secure unit and models of care used. Family members interviewed state that this and the good communication provided by staff helps them adjust to levels of care required by their family member. The service is preparing to update the information to include the new unit with input from the District Health Board.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. The families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The service uses Medimap – an electronic system for prescribing and administering of medications. The medicines management system is implemented to ensure that residents receive medicines in a secure and timely manner and medicine charts sampled complied with legislation, protocols and guidelines. Medicines were stored safely and securely in the clinic room. The registered nurse was observed administering medicines on both days of the audit. The medication trolley is locked when medication is being administered to a resident. The organisation uses pre-packed medicine packets which are checked by the registered nurse on delivery. Medicine reconciliation is recorded. All medicines are reviewed every three months and as required by the general practitioner with documentation maintained on Medimap. Allergies and alerts are documented. Photographs are sighted on all files reviewed with these dated indicating that they are a true and correct record. An annual medicine competency is completed for all staff administering medicines with training records sighted. There is a safe that is locked inside a locked cupboard and this stores any controlled drugs. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medicines are stored appropriately. Documentation of controlled drugs is as per policy. Balances checked on site of controlled drugs confirmed that these matched the register. There are no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner. There are no residents self-administering their medicines at the time of the audit in the dementia and psychogeriatric unit. Staff can describe the process for assessing residents as competent to do so should there be residents in the residential disability – psychiatric unit who are able to self-administer medications. Each bedroom in residential disability – psychiatric unit has a wardrobe that is able to be locked and anyone who self-administers their medications would be able to store medications in a secure safe place. A self-administration policy and procedure is in place and this includes establishing competency and supervision of any resident self-administering medication. The trolley for medications currently used in the dementia and psychogeriatric unit will continue to be used for the residential disability – psychiatric unit with the same storage area used for medications. The clinical coordinators and registered nurses interviewed can describe how medication will be administered to residents in the unit.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Meal services are prepared on site and served in the dining area. The menu has a four-week rotation and is a winter and summer menu. The menu has been developed and reviewed by a dietitian. The dietician has a current annual practicing certificate. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes. The cook has a copy of the dietary profile in the kitchen. The resident’s weight is monitored regularly and supplements are provided to residents with identified weight loss issues or for residents who have difficulty eating at times. The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers with pantry food rotated. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. All temperatures are checked daily and are recorded as being with the appropriate range. Regular cleaning is undertaken with daily cleaning checks of the kitchen documented. The service provides additional food over a 24- hour period for residents who require snacks outside of meal times. The family interviewed indicated satisfaction with the food service. The main kitchen will prepare and serve food onto plates. The service has a trolley which keeps food hot or cold and this will be used to transport meals to residents in the residential disability-psychiatric care unit. Residents will have access to a kitchenette where they can make hot drinks. Food can also be served from the kitchenette.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The manager reports that all residents who are declined entry are recorded on the pre-enquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The resident is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.Each resident record reviewed during the audit confirms that the resident is receiving the appropriate level of care as assessed by the Needs Assessment Service.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission with these reviewed six monthly. Relatives expressed satisfaction with the assessment process which they stated included their input. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. Short term care plans and behavioural plans are developed from triggers identified in the interRAI assessment. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and long-term care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the general practitioner. Progress notes are completed on every shift with the registered nurse documenting notes at least every three days. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Family interviewed report satisfaction with the care and support they are receiving. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they modify activities based on the resident’s response and interests and according to the capability and cognitive abilities of the residents. The residents were observed to be participating in meaningful activities on the audit days. Each resident has a 24-hour activity plan in place that links with the long-term care plan for management of challenging behaviours. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The relatives interviewed reported overall satisfaction with the level and variety of activities provided.The manager has had discussions with the Taranaki District Health Board around expectations for activities in the residential disability – psychiatric unit. Residents are expected to access community activities and this will be built into the care plans via the assessment process. The staff role is expected to be to support and encourage engagement in meaningful activities that support recovery. This is documented in the policy manual.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident’s long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem is resolved. |
| 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 | There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The general practitioner confirmed that processes are in place to ensure that all referrals are followed up accordingly. The family state they are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or general practitioner. |
| 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 | Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Copies of material safety data sheets are available to be put into the residential disability – psychiatric unit. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis.Chemicals are stored securely and the required personal protective equipment/clothing (PPE) is available. Staff confirm they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required. There is a large locked storage room in the residential disability – psychiatric unit and this already stores chemicals and other products for use when the unit opens. The health care assistants demonstrate knowledge of handling waste and chemicals and were observed to keep the cleaning trolleys in sight when in use. Cleaners are particularly vigilant around keeping chemicals safe and in sight when in use at all times. Cleaners work seven days a week and other staff clean if there is a need on the afternoon and night shift. The cleaners document a task list indicating that all areas have been cleaned and the night shift staff also complete a cleaning and maintenance checklist that ensures that any extra household tasks have been completed. Waste is mostly of a domestic-type and is managed via a recycling programme or by local council contracted services. There is a contract with an external company to take waste away. Medical hazardous waste is collected by an external contractor. Waste in the eight-bed unit will be collected by existing providers.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current warrant of fitness in August 2018. There is a code of compliance for the residential disability – psychiatric unit (issued 12 July 2017). The residential disability – psychiatric unit and the dementia and psychogeriatric services are connected under one roof. The residential disability – psychiatric unit is separated from the psychogeriatric unit by a door currently locked from the inside. The owner has contacted an external provider to put a pin code lock on the door so that residents will not be able to go to and from and into either unit noting that staff will be able to enter and exit at any time. The residential disability – psychiatric unit is not secure and has its own external area, outdoor seating and shade and a separate outside access to the unit. It also has a driveway to the unit that is separate from the driveway and parking area for the secure units.The service has had a waiver from the Taranaki District Health Board to keep residents identified as dementia or psychogeriatric level of care in one area. The facility is ready to separate the two areas with pin codes on doors. The intention is to separate the units as soon as the certification and partial provisional audit has been approved by HealthCERT. Planned and reactive maintenance is implemented by the owner and contractors as required. The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of residents. There are outdoor areas available for all residents including outdoor garden areas in the secure unit. Once the areas are separated, there will continue to be outdoor areas and circular paths for both the dementia and psychogeriatric units. Perimeter fencing ensures that residents are secure in both the dementia and psychogeriatric units.The electrical equipment is checked annually and records maintained. Testing and calibration checks of medical measuring equipment occurs annually. The service has vehicles for transporting residents. There is a system for managing the vehicle warrant of finesses, ensuring that there are current registrations and that staff who drive any residents have a driver’s license that is current. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | There are sufficient toilets, hand basins and showering facilities available for residents in the secure unit. Once the dementia and psychogeriatric units are separated, there will still be sufficient numbers of toilets and shower facilities to meet resident needs. These are placed in accessible areas. Hand basins are in each bedroom and in communal areas. The residential disability – psychiatric unit has a communal toilet and shower unit and two bedrooms have an ensuite (refer 1.1.3). There are appropriate privacy protections in place when showers and toilets are in use in the secure unit with these observed to be used on the days of audit.  |
| 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 | All residents have their own bedroom. Doors into each bedroom are either one and a half doors or have large stable doors. The residential disability – psychiatric unit has large individual bedrooms for up to either residents. Each has a built-in wardroom and drawers and all have one and a half doors. Each room is able to have additional equipment and more than one staff member in the room at any time if additional cares were required. All rooms are able to be accessed by emergency staff and the ambulance if required can drive to the door of the facility. There is ample room for mobility aides to be used safely in each resident’s room in any unit. Residents confirm that there is sufficient space in each room for personal items and residents in the secure unit have personal items in their room.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge in the secure unit that includes a dining area and space for activities. Once separated, there will be separate dining and lounge areas in both the dementia and psychogeriatric units. Both areas will be able to have separate activities in the lounge areas. There are also quiet areas for residents and a sensory room currently being put in place. There are smaller rooms available throughout the building with comfortable seating for family/visitors and group meetings. The residential disability – psychiatric unit has a combined dining and lounge area that can be used for activities. There are quiet spaces for residents if they require these.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are separate laundry and linen service manuals available containing all relevant cleaning and laundry policies and procedures to guide staff. Staff know how to access the information and can describe implementation as per policy.The service employs cleaners seven days a week and the cleaners will also be responsible for ensuring that the residential disability – psychiatric unit is kept clean. The cleaning staff hours will be increased by one hour to account for the extra cleaning requirement. All cleaning processes are documented clearly for each area of service. Current cleaning staff can accommodate cleaning requirements for the residential disability-psychiatric care unit. There is adequate storage for all chemicals in locked designated areas. There is a cleaning schedule in place with documented daily cleaning tasks to be completed. Cleaning checklists are maintained daily to ensure that duties are completed.Laundry is performed by dedicated staff seven days a week. There is a large laundry on site that contains commercial grade washing machines and a clothes dryer and an outside drying area. There is dirty and clean separation in the laundry. The laundry staff and health care assistants who might soak clothes when laundry staff are not present were able to describe procedures including soaking and washing of soiled and/or infectious linen. The residential disability – psychiatric unit will use the same laundry service with the laundry staff hours increased by one hour to account for the extra requirements. The door into the psychogeriatric secure unit has pin code access (refer 1.2.4) with covered laundry trolleys able to take the dirty laundry to the designated area. The laundry is directly beside the residential disability-psychiatric care unit. Laundry staff have the capacity to wash, dry and return laundry to the residential disability-psychiatric care unit. There are material data sheets available for all chemical products used for cleaning and the laundry. The facility manager monitors the cleaning and laundry service through the internal audit programme to ensure resident and relative satisfaction is maintained. The facility was observed to be clean with policies for cleaning and laundry services well implemented during the audit. Relatives interviewed confirm satisfaction with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is a New Zealand Fire Service approved evacuation scheme issued in July 2017 that includes the residential disability – psychiatric unit. Emergency drills take place at least six monthly with the drill last held in February and August 2017. Training is also provided around emergencies and security from a health, safety and reporting perspective annually. Training including drills will be rolled out to include the residential disability – psychiatric unit when occupied. All doors automatically unlock if the fire alarm is activated. Staff training includes the new unit. In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare battery lights, a gas barbecue, linen, continence products, torches and batteries, water, gas heaters, and a gas stove. Food dry stock and frozen food are available for at least three days. An electric call bell system is available throughout the three units including call bells in the residential disability – psychiatric unit. The call bells in all units including the residential disability – psychiatric unit can be heard and seen in each unit. There are also monitors in the nurse’s rooms in each unit so that if staff are completing notes or having meetings, then call bells can still be seen. Security is maintained with staff checking doors at all times to ensure that the dementia and psychogeriatric doors to the community are locked. Any outdoor area able to be accessed by residents in the secure unit is able to be accessed at any time. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. This will continue for the residential disability – psychiatric unit. The owner, manager, staff on call or emergency services can be contacted if staff are concerned or if an emergency occurs. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms have an external window that can be opened for ventilation. The buildings are ventilated by opening windows and doors and sky light windows. Heating is managed by use of a mix of underfloor heating in the residential disability-psychiatric care unit with individual means of adjusting in each bedroom; heaters in the hallway in the residential disability – psychiatric unit. The rooms were heated appropriately on the days of audit. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | Sunhaven provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical coordinator is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift (observed during the audit) and progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.The ICC and the clinical coordinator who was the previous ICC have both had input into the residential disability – psychiatric unit. The manager confirmed this. The ICC will include the residential disability – psychiatric unit as part of the role.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health board staff. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.The ICC has completed on-line training for IC in 2017.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at registered nurse and staff meetings and through compiled reports. The GP is informed within the required period when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.The clinical coordinator is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Information gathered is clearly documented in the infection log maintained by the infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented. \When infections were sighted as occurring in files reviewed, these were checked in surveillance data. All were recorded and data used to review outcomes both for the individual and the facility. The IC coordinator will include surveillance data for residents using the new unit as a separate entity.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a restraint minimisation policy. This includes methods for minimising restraint and approved alternatives. Definitions of restraint and enablers are consistent with this standard. Records sampled confirm that staff actively work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and quality management team meetings. All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.There is currently one resident who are uses a restraint for safety and comfort. Enablers are not used as residents are not able to give consent. Both the dementia and psychogeriatric units are secure because of the nature of the service delivered.  |
| Standard 2.2.1: Restraint approval and processesServices 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 coordinator is a registered nurse. The restraint coordinator is supported by the clinical coordinators regarding restraint practice and quality and risk considerations. The role of the restraint coordinator is documented. The use of all restraints is provided in reports to the staff and quality management team.The use of restraint must be approved by the restraint coordinator, including the family and GP. The approval process is comprehensive and requires a full assessment of risk and evidence of trialled alternatives. The required approvals were sighted in restraint records sampled. Approved equipment which can be used as a restraint includes low beds, bed rails, lap belts and recliner chairs. There is one resident who has been assessed and approved to have a bedrail in use as their limbs spasm. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint assessment process is fully documented and includes the requirements of this standard. Resident records sampled confirmed completed assessments and approvals. Assessments and approvals were signed by the family, the GP and the restraint coordinator. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The reason for implementing a restraint in the records sampled was for safety reasons. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | A current updated register was sighted. The long-term care plan has documented risk management plans required to ensure the resident’s safety while on restraint. The service has an approval process as part of the restraint minimisation policies and procedures that is applicable to the service and accessible to staff to read. Restraint authorisation is in consultation with resident, family, restraint co-ordinator and GP. The approval process ensures the environment is appropriate and safe. Restraint use is reviewed at least three monthly and six monthly and as part of restraint register reviews. Staff interviewed demonstrated understanding about restraints and strategies to promote safe practice.The restraint monitoring and observation process is included in the restraint policy. There were no restraint related injuries reported. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | Regular reviews are conducted on residents and this was evident in the records sampled. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family confirmed involvement in restraint use. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long-term care plans. Evaluations time frames are determined by the risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The service has demonstrated monitoring and quality review on the use of restraint. Restraint updates are included in the registered nurse, staff and continuous quality meetings. Individual approved restraints are completed three to six monthly through restraint meeting and as part of the facility approval team review with family involvement. Meeting minutes confirmed discussions on restraint are being conducted and included review of restraint use. The restraint coordinator reported that assessments and monitoring are appropriate. Policies and procedures are up to date and training record sighted and annual reviews are done. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.3.1The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times. | PA Low | There is a communal shower and toilet in the non-secure unit for residents requiring residential disability-psychiatric care. The shower unit has a lock that ensures that there is privacy for the resident showering. The toilet is outside the shower room. There is an outside door into the hallway that can be locked when the shower and toilet is in use. There is a shower curtain around the toilet. If the shower is in use, then the toilet is not able to be used as the resident would have to pass by the toilet and into the hallway. | There is potentially a lack of privacy for any resident using the communal toilet in the residential disability-psychiatric care unit and the toilet may not be able to be accessed for any other resident if the shower room is in use | Ensure that any resident can access the toilet with privacy maintained at all times.Prior to occupancy days |
| Criterion 1.4.2.4The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The non-secure unit for residents requiring residential disability-psychiatric care is separated from the secure unit by doors that are currently locked from the non-secure unit for residents requiring residential disability-psychiatric care side with a slide bolt. The intention is to put a pin code on with an external contractor already organised to address. There is one door in the residential disability-psychiatric care unit that goes into the internal courtyard in the secure unit and the intention is to lock this securely so that the courtyard cannot be accessed by residents using the residential disability-psychiatric care unit. The service has had an exemption from the Taranaki District Health Board to combine residents requiring dementia or psychogeriatric care into one area. The facility can separate the two services and is waiting for the audit to confirm that the facility meets all requirements.  | Doors that separate the non-secure unit for residents requiring residential disability-psychiatric care and psychogeriatric unit are only temporarily secure from the residential disability – psychiatric unit. Residents requiring dementia or psychogeriatric level of care are currently sharing one space.  | Secure the psychogeriatric unit from the residential disability – psychiatric unit. Separate the dementia and psychogeriatric units. Prior to occupancy days |

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

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

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

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

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| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | CI | There is an annual training plan implemented with staff also trained in dementia including management of challenging behaviour. The staff have access to and receive expert advice from other external health professionals. Specific training is available to upskill ‘experts’ within the service who act as a resource for others. All state that any challenging behaviour is managed competently with training applied to ensure that there are positive outcomes for all residents. The family members, care staff and clinical coordinator interviewed confirm that residents are treated with respect with dignity maintained at all times. The manager and clinical coordinators state that they constantly review the training programme to ensure that it continues to fit the needs of residents. Evaluation of each training session is documented and any improvements incorporated into further training.  | The owner and manager state that they believe education is important and ongoing. There is an annual training plan implemented with staff also trained in dementia. Sunhaven has been assessed by the New Zealand Nursing Council and has met the requirements to accept a clinical placement for a New Zealand Nursing Council approved competency assessment programme since November 2016. Students undertaking clinical placement are overseen by an experienced registered nurse while completing studies. The programme has been operational for three years and all three registered nurses who train the students have their preceptorship through ‘Training (Avatar Institute)’Sunhaven arranges education programmes for families and staff facilitated by an external provider who has completed a Masters in Dementia. In 2017, the ‘Better for Everyone’ was attended by seven staff. The staff also have access to and receive expert advice from other external health professionals including mentorship for the infection control coordinator and training from the general practitioner who is also a psychogeratrician. The service has subscribed to an external group for infection control information and to the Wound Care Society. Staff can access information and complete online courses. The service has also subscribed to Golden Carers for the diversional therapist facilitating the activities programme. Specific training is available to upskill ‘experts’ within the service who act as a resource for others. One registered nurse for example, has attended a seven-hour study day in July 2017 around wound management and has been booked for an integrated wound study day in September 2017 to further extend knowledge.The family members and RG interviewed confirm that residents are treated with respect with dignity maintained at all times. All state that any challenging behaviour is managed competently with training applied to ensure that there are positive outcomes for all residents. Staff can describe how they apply the training and knowledge they receive and this was observed to be put into practice on the days of audit.Each training session has a plan and information ready for the presentation and discussion. Attendance records are maintained. The training sessions are evaluated with information used to improve quality of further training sessions. Staff state that the information is useful and they are able to improve practice as a result of the training. Relatives state that staff talk about improvements and information they have learnt from training. They also all praise staff for the way in which they deliver care and provide information that supports them as family and their relative.  |

End of the report.