# Bima Health Limited

## Current Status: 14 January 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Sunhaven Rest Home and Private Hospital (Sunhaven) is a privately owned psychogeriatric and dementia care facility in Bell Block New Plymouth. The service can provide care to a maximum of 37 residents. On the day of the audit there were 35 residents; 18 receiving psychogeriatric level care and 17 receiving dementia level care.

Of 14 areas for improvement identified at the certification audit in November 2012, 12 have been addressed. Some improvement has been made in the two remaining areas but there is still progress to be made to fully address these. They relate to the medicine management system and the monitoring on the now recorded risk management plan. Five new areas for improvement have been identified, making a total of seven areas for improvement to be addressed by the provider.

There has been a change in the care manager, with the new incumbent commencing work at Sunhaven in late November 2013. This person brings a wide range of both nursing and management experience to the role. There is a facility manager who has been at Sunhaven for eight years.

## Audit Summary as at 14 January 2014

Standards have been assessed and summarised below:

### Key

| **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 |

### Consumer Rights as at 14 January 2014

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

### Organisational Management as at 14 January 2014

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

### Continuum of Service Delivery as at 14 January 2014

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

### Safe and Appropriate Environment as at 14 January 2014

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

### Restraint Minimisation and Safe Practice as at 14 January 2014

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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. |

### Infection Prevention and Control as at 14 January 2014

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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. |

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

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| **Legal entity name:** | BIMA Health Ltd ( Sunhaven home and hospital) |
| **Certificate name:** | Sunhaven Rest Home and Private Hospital |

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| **Designated Auditing Agency:** | DAA |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Sunhaven Home and Hospital | | | |
| **Services audited:** | Dementia and psychogeriatric | | | |
| **Dates of audit:** | **Start date:** | 14 January 2014 | **End date:** | 14 January 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 35 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXX | **Total hours on site** | 8 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 4 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 18 | Total audit hours | 34 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 1 | Number of staff interviewed | 8 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 33 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of the DAA | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAA has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | the DAA has provided all the information that is relevant to the audit | Yes |
| h) | the DAA has finished editing the document. | Yes |

Dated Friday, 7 February 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Sunhaven Rest Home and Private Hospital (Sunhaven) is a privately owned psychogeriatric and dementia care facility in Bell Block New Plymouth. The service can provide care to a maximum of 37 residents. On the day of the audit there were 35 residents; 18 receiving psychogeriatric level care and 17 receiving dementia level care.   Of 14 areas for improvement identified at the certification audit in November 2012, 12 have been addressed. Some improvement has been made in the two remaining areas but there is still progress to be made to fully address these. They relate to the medicine management system and the monitoring on the now recorded risk management plan. Five new areas for improvement have been identified, making a total of seven areas for improvement to be addressed by the provider.   There has been a change in the care manager, with the new incumbent commencing work at Sunhaven in late November 2013. This person brings a wide range of both nursing and management experience to the role. There is a facility manager who has been at Sunhaven for eight years. |

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| **Outcome 1.1: Consumer Rights** |
| Sunhaven staff and managers practice open disclosure in their communications with residents and family/whanau. Evidence reviewed during the onsite audit confirms this.   There is a complaints and compliments register which is current and complaints are dealt with promptly. |

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| **Outcome 1.2: Organisational Management** |
| The mission, vision and scope of the organisation are described in their business plan and the mission is included in position descriptions. There is now a documented succession plan for the absence of either the care manager or facility manager and this previous area for improvement is addressed.   There is detailed quality management system which is implemented and known by staff members. Exceptions to expected service delivery are identified and documented by staff members. Collated data is analysed for trends and corrective action taken when necessary to improve services.   The organisation now has a documented risk management plan which identifies risks to the business and strategies for managing these. However, at the time of audit the plan had not yet been monitored or risks reviewed and this aspect of the previously identified area for improvement needs to be addressed. The organisation has had a contract audit in September 2013 which also identified this as an area for improvement, and there a report indicating a corrective action is due in relation to this by the end of February 2014. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Residents who enter Sunhaven are assessed by the Needs Assessment and Co-ordination Service (NASC) as requiring the services provided by Sunhaven. The service is under the guidance of a recently appointed care manager, who is in the process of a systems review.  Recently admitted residents have no initial care plan completed within 24 hours of admission. The full care plan is not developed within three weeks of admission, while care plans of some residents have not been evaluated within the last six months. The provision of service/interventions are not consistent with meeting the consumers’ assessed needs or desired outcomes. These are areas requiring improvements.   The previous corrective action request concerning Medical review remains ongoing. No documented evidence on site supports a medical review being undertaken on a recent admission, although a signed medication chart is sighted. Other residents have medical reviews undertaken outside the specified requirement.    Verbal handover and oversight by the registered nurse (RN) informs care staff of resident need.   There is no identified documented planned activities programme operating or activity assessments occurring at the time of audit and this is an area requiring improvement. Entertainment is being provided by community sources until the new activities programme commences.   Medication records sighted contain adequate detail to comply with legislation and guidelines. As per a previous required improvement, some medication charts have a medication request not yet signed by the GP, although the pharmacy has dispensed the medication based on a prescription received. A drug review for a specific resident has not been undertaken by the GP as requested, and there is no documented evidence of three monthly medication reviews having occurred. These are areas that continue to require attention. A previous required improvement around competencies and standing orders has been addressed.  Residents' nutritional needs are provided in line with guidelines for older persons' nutritional needs, as assessed by a dietician. The food service policies and procedures are appropriate and comply with current legislation and guidelines. Meals are well presented and nutritious. Residents’ food input is monitored and recorded at each mealtime and residents assisted when they are distracted from eating, to enable appropriate action before weight loss occurs. The cook and all kitchen staff have appropriate food safety qualifications. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has a current building warrant of fitness. Two previous areas for improvement relating to the facility have been addressed. There is now a documented pandemic plan as part of the organisation’s emergency planning manual, and a 2500 litre water tank for emergency water supplies, and gas-fired barbeque for cooking should main utility supplies fail. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint minimisation is practised at Sunhaven and the least restrictive options are used to safely support residents. The use of enablers and other assistive equipment is voluntary and residents are independently mobile.   Four previous areas requiring improvement have been addressed by the organisation. The restraint and enabler policy and procedure now includes a definition of enablers consistent with this standard; approved restraints are included in the policy and are regularly reviewed; and staff members attend training and have competency assessments and a record of this is maintained. |

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| **Outcome 3: Infection Prevention and Control** |
| The Sunhaven infection control and prevention programme is implemented by the infection control nurse. Resources allow for a managed approach to minimise the risk of infection to all users. Surveillance data, of all eye, urinary tract, respiratory tract, skin and soft tissue infections, is collected by the care manager who is the infection control nurse. Data is collected, monitored, evaluated and reported at ‘CQI’ meetings. Surveillance data from the facility is benchmarked against previously collected data on a monthly basis. Data is graphed and available to all staff in the staff room. Data is reported to staff at bi-monthly staff meetings. If data indicates an increase in infection activity, analysis occurs to determine a cause and corrective actions put in place. Any immediate actions needed are presented at duty handover. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 1 | 0 | 5 | 1 | 0 |
| **Criteria** | 0 | 33 | 1 | 0 | 5 | 1 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Negligible |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.9 | Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Negligible | There is no evidence that risks identified in the facilities risk management plan have been monitored or reviewed. A finding at a contract audit in September 2013 has also identified this issue and is due to be reported on to the DHB by 28 February 2014. (The risk is lowered because this has previously been identified at another audit event.) | Ensure that the monitoring, review and evaluation of the risk management plan occurs regularly and is incorporated into the quality systems of the facility. | 60 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Each stage of service provision is not within time frames that safely meet the needs of the residents. | Each stage of service provision must be provided within the required tine frames to safely meet the needs of the resident. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Service delivery plans do not describe the required support and / or intervention to achieve the desired outcomes. | Service delivery plans describe the required support and / or intervention to achieve the desired outcomes. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Interventions are not consistent with meeting the residents’ assessed need and desired outcomes. | Interventions are consistent with meeting the residents’ assessed need and desired outcomes. | 90 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | Activities are not planned to develop and maintain strengths that are meaningful to the resident. | Activities are planned to develop and maintain strengths that are meaningful to the resident. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.2 | Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Evaluations are not documented or are not reviewed six monthly or as needs change. | Ensure evaluations are documented and indicate the degree of achievement related to the desired goal. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA High |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.6 | Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA High | Medication requests do not always have written authorisation from the resident’s GP. | Medication management documentation is to comply with legislation and guidelines. | 30 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Communication occurs openly at Sunhaven. The facility manager (FM) and care manager (CM) both have an open door policy which is verified by both staff interviews, family/whanau interview (1 of 1) and records of annual satisfaction survey and event reporting. There is a communication book maintained by staff which records all external contact, including with family/whanau.   The contact information for family/whanau and enduring power of attorney (EPOA) for each person includes their requests for contact and information.    The provision of interpreter services is included in the facilities policies and procedures. Staff indicate an understanding of how to access interpreter services if needed.   The ARC and ARHSS requirements are met. |

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.1.13: Complaints Management **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The FM maintains a complaints and compliments book. This includes the date of receipt, the nature of the communication (complaint or compliment), details of action taken and outcome. The book is current and up to date.   A recent complaint was made directly to the DHB. The portfolio manager made an unannounced visit to Sunhaven to investigate the complaint. A copy of her letter to the complainant was sent to the FM and sighted during the audit. This indicated that the portfolio manager was both satisfied the complaint was unfounded and that Sun haven’s response in the situation (a potential outbreak of scabies) was appropriate and all necessary action was taken.   The ARC and ARHSS requirements are met. |

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation’s values, scope, purpose, direction and goals are described in their business plan, in job descriptions and contained in information given to residents and family/whanau on entry to the service. The business plan is dated 1 April 2013 – 31 March 2014. There are regular (monthly) Continuous Quality Improvement (CQI) meetings which include monitoring of these goals.   The FM has been at Sunhaven for eight years and is experienced in her role. The CM has been at Sunhaven for six weeks, since late November 2013. She is a registered nurse and has previously managed a rural hospital in the Hawke’s Bay region for 10 years. Her curriculum vitae was sighted and demonstrates that she has a broad range of nursing experience (including acute and emergency care, intensive care, and geriatric care) as well as being a nurse manager in a range of positions in the UK and New Zealand. At interview she demonstrates a sound understanding of the role, contractual requirements in the aged care sector and those of the sector standards.   Both the FM and CM have a job description which describes their roles, responsibilities and accountabilities. Copies of these are current and on the personnel files.   A previous area for improvement related to this standard has been addressed (1.2.2.1). The organisation has a documented succession plan included in their policies and procedures which describes the succession plan in the temporary absence of either the care manager or facility manager.   Staff interviewed report that the two managers are approachable, experienced and provide them with effective support and direction in their roles.  ARC and ARHSS contract requirements are met. |

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

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| **Attainment and Risk:** PA Negligible |
| **Evidence:** |
| The organisation has a defined and document quality management system which is appropriate to the size and scope of the facility. The quality plan identifies the event monitoring (i.e., incidents, accidents, complaints, compliments, medication errors, infections, use of restraints). These are reported on and collated by the CM, FM and health and safety representative. Collated results are reported to staff via the monthly management team meetings, the monthly CQI meetings and the two monthly staff meetings.   The health and safety representative (one of one) was interviewed and described her process for monitoring events as they occur, ensuring the CM has been notified when this is relevant to the event, reviewing all reports and collating data on a monthly basis and preparing graphs of event data for the staff meetings.   Document management and control is undertaken and monitored by the FM and CM. Documents reviewed on the day of the audit are current, up to date, and document controlled.   A range of other staff members were interviewed during the audit including RNs, caregivers, one laundry staff member, and the kitchen and cleaning staff members on duty on the day of the audit (seven), and the FM and CM, report that they are informed about collated and analysed quality improvement data and any identified trends. When appropriate, trends and information are reported to family/whanau members via the regular (two monthly) newsletter.    There is now a documented risk management plan and summary chart, which identifies the financial, occupancy, staffing and other risks to the service. The plan includes risk management and monitoring activities as well and there is a process for reviewing risks. There has not yet been any monitoring or review of risks and an area for improvement is identified in relation to this.   There is a range of internal audit tools which are used to monitor all aspects of service delivery. These include corrective action plans when necessary due to the results of any audit. A review of randomly sampled internal audits completed in 2013 demonstrates that when necessary corrective plans are developed and implemented. These are monitored through the CQI meetings. The September 2013 contract audit identified that a clinical audit conducted in 2013 had not had a corrective action plan developed in response to the audit. Progress reporting to the DHB has occurred in relation to this finding and is due to be sent to DHB by 31 January 2014.  ARC and ARHSS contract requirements are met. |

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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| **Attainment and Risk:** PA Negligible |
| **Evidence:** |
| There is now a documented risk management plan, and summary chart, which identifies the financial, occupancy, staffing and other risks to the service. The plan includes risk management and monitoring activities as well and there is a process for reviewing risks. The FM reports that there was a scheduled management team meeting at which the team would review and monitor risks for the first time. This was scheduled to occur on the day of this unannounced surveillance audit and so had not occurred. This was also identified at a routine contract audit of the service by the DHB and is due for reporting to them at the end of February 2014. An area for improvement is identified in relation to this. The risk level is negligible because this is already identified and reporting is scheduled to occur in the near future. Earlier reporting on other findings from this event has occurred on time, and was reviewed during the audit. |
| **Finding:** |
| There is no evidence that risks identified in the facilities risk management plan have been monitored or reviewed. A finding at a contract audit in September 2013 has also identified this issue and is due to be reported on to the DHB by 28 February 2014. (The risk is lowered because this has previously been identified at another audit event.) |
| **Corrective Action:** |
| Ensure that the monitoring, review and evaluation of the risk management plan occurs regularly and is incorporated into the quality systems of the facility. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.4: Adverse Event Reporting **(**HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation’s quality management system includes guidance for staff in essential notifications. There have been no incidents or events which require essential notifications since the last on site audit.   Adverse events are documented and monitored by the health and safety representatives, with oversight by the CM, who will also manage the response to an event when necessary. Events are collated by the health and safety representative, and analysed by the CQI committee. Any trends, and corrective action in response to these, are reported to staff verbally, through memos and at the regular staff meetings.   ARC and ARHSS contract requirements are met. |

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.7: Human Resource Management **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Sunhaven has policies and procedures which provide for the management of employees that are consistent with current good practice. This includes the validation of professional qualifications of the registered nurses employed by the organisation, the GP, and records the qualifications of all other staff members.   A sampling of ten staff members’ personnel files confirms that all have a completed induction checklist (or one which is underway for very new staff), a position description, individual employment agreement, police check, and record of the person’s recruitment, including their CV. There is an induction checklist which covers the essential components of employment at Sunhaven and the delivery of services. This is completed during the first six weeks of employment.   There is a training calendar which incorporates the essential components of service delivery, so that staff have their knowledge refreshed over time, and development for staff. At interview (seven staff and two managers) report that they are able to request specific training relevant to their roles and which enables them to develop over time.   ARC and ARHSS contract requirements are met. |

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

The appointment of appropriate service providers to safely meet the needs of consumers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented staffing policy which provides for a minimum of one RN and one caregiver, with additional staff to meet the needs and number of residents and sufficient other staff to ensure safe and appropriate care.   Appropriately skilled and / or qualified staff are employed. Staffing levels are appropriate to the number of residents supported and include: • Monday – Friday the CM works 8am to 5pm, and is on call outside these hours • Monday – Friday the FM works 8am to 5pm • Daily there is one laundry person 9am to 3pm , one domestic (cleaner) 9am to 2.30pm and one kitchen staff members (cook) 8am – 1pm and 2.45 – 6pm • Mornings – 7am to 3pm – four care givers plus one assigned to the lounge and one RN • Afternoons – 3pm to 11.15pm – four care givers ( one of which is assigned to the lounge) a 5pm- 9pm care giver and one RN. • Nights – 11pm to 7am – one caregiver, one domestic assistant, and one RN  Staff interviewed during the audit (seven staff and two managers) report that there are sufficient numbers of staff to provide adequate care and ensure safety. Satisfaction survey responses (16 of 28 sent out) confirm that staffing levels are appropriate.   ARC and ARHSS contract requirements are met. |

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.3: Continuum of Service Delivery**

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.

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service is under the guidance of a recently appointed Care Manager, whose focus is to manage and minimise disruptive behaviours and the predisposing factors that can exacerbate those behaviours. She is a Registered Nurse, with experience in acute care areas and management. She is at present undertaking additional training to improve her knowledge in dementia.   Initial admission assessment and documentation is sighted in two of three hospital files and one of two rest home files. These assessments and care plans are last updated in June 2013. One of three hospital and one of two rest home residents recently admitted; have no initial care plan completed within 24 hours of admission. The full care plan is not developed within three weeks of admission. These are areas requiring improvement.  The recently appointed Care Manager reports there are six RNs employed. No present system operates to assist the RNs to manage the ongoing update and review of care plans. The CM is managing the process to ensure this happens.  During the admission process by the RN, residents and family / whanau are included in discussions about care needs and requirements, as confirmed by interview with one of one resident, a family member, the Care Manager, RN and sighted in two of three hospital and one of one rest home files. Discussion with family is well documented in these files, though absent in one of three hospital and one of one rest home files. The initial assessment in two of three hospital files and one of two rest home files is signed by the RN and the resident or family / whanau, to confirm they agree with what is written.  Interview with the newly appointed Care Manager, concerning lack of up to date documentation, verifies staff are aware of resident need by verbal handover and close RN supervision and involvement, until documentation processes are updated and implemented. Staff are sighted implementing critical behaviour management strategies specific to each resident’s episode of disruptive behaviour, and interviews with two of two care staff verified their understanding of specific resident’s needs.  Resident’s nutritional needs/dislikes, despite no documented evidence of assessment in the care plans, is recorded on the white board in the kitchen for the cook to attend to in menu planning. Interviews with one of five registered nurses and the Care Manager, confirm that ongoing assessment, planning, review, evaluation and update of residents' care plans will be done by the resident’s primary nurse who is a registered nurse.  Interview with the community liaison nurse from the DHB psycho-geriatric team, is highly complementary of Sunhaven and its recently appointed Care Manager. The working partnership between the services has seen a vast improvement in the service offered by Sunhaven and the care provided to residents. She expressed no concerns in regards to care being provided.  Caregivers work under the direction of a Registered Nurse each shift and are allocated the residents they are responsible for at the beginning of each shift. Those caregivers attend to those residents needs for the entire shift, write the progress notes, and hand over any concerns to the RN. There are handovers between shifts where information related to residents is passed on verbally by the RN and the Care Manager. The nurses and caregivers use a white board to ensure all appropriate changes are notified.  Sighted documentation from three of three hospitals and two of two rest home files supports service provision being undertaken by competent service providers. Practising certificates are sighted for all staff that require them. Caregivers employed have completed or are in the process of completing their Aged Care Education and Dementia training. Two of two caregivers, one of one cleaner, one of one laundry person and one of one cook verify recent training in infection control, and how to manage a resident if they become disruptive. Two of two caregivers verify recent training and understanding of restraint. The cook has NZQA certificates 167 and 168, in Safe food handling.  Initial and ongoing review of the activities programme has in the past been performed by the activities person. At the time of audit no activities person is employed and no ongoing activities programme is sighted. Outside entertainers are visiting and are present on the day of audit. (Refer 1.3.7).  Initial and ongoing medical and medicine review is provided by the facilities general practitioner (GP). The interview with the GP, confirms she visits the home every second Thursday and when required, that staff carry out her requests promptly and accurately and staff at Sunhaven make appropriate contact with her as needed. There is a documented arrangement for afterhours cover. She stated she is impressed with the skills of the newly appointed Care Manager.  One of two rest home residents admitted a month ago, has no documented evidence on site to support a medical review has been performed, though a signed medication chart is sighted. This requires attention. The doctor is due to visit and will be requested to document a medical review. One of two rest homes and three of three hospital files, have medical reviews greater than monthly, with no documentation to support they were medically stable and did not require monthly reviews. This is an area previously identified as requiring corrective action, and is identified as still requiring action.  Tracer 1 - A Hospital resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer 2 - A rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| One of three hospital and one of two rest home residents recently admitted have no initial care plan completed within 24 hours of admission. The full care plan is not developed within three weeks of admission. The care plans of two of three hospitals and one of one rest home residents has not been evaluated within the last six months.  One of two rest homes and three of three hospital files reviewed have medical reviews greater than monthly, with no documentation to support they are medically stable and do not require monthly reviews. One of two rest home residents admitted a month ago, has no documented evidence to support a medical review has been performed. |
| **Finding:** |
| Each stage of service provision is not within time frames that safely meet the needs of the residents. |
| **Corrective Action:** |
| Each stage of service provision must be provided within the required tine frames to safely meet the needs of the resident. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The recently appointed Care Manager, reports at the time of this audit, residents have no specific RN appointed to them, to manage the regular reviews and updates of the residents care plan, although she is managing the process to ensure this happens. One of three hospital and one of two rest home residents recently admitted have no initial care plan completed within 24 hours of admission. The full care plan is not developed within three weeks of admission. Initial admission assessment and documentation sighted in two of three hospital files and one of two rest home files is undertaken by the previous clinical co-ordinator (RN). These assessments and care plans are last updated in June 2013. The care plans of two of three hospital and one of one rest home resident has not been evaluated within the last six months. These are areas requiring improvement. (Refer 1.3.3, 1.3.6 and 1.3.8) The care plan does not describe the required support /intervention to achieve the desired outcome. No plan exists for the management of resident’s behaviour, despite complex interventions (observed) occurring to manage disruptive outbursts, and promote the comfort of all concerned. The plan identifies the resident has a catheter. This has since been removed though care plan does not mention this. A recent fall resulting in a laceration requiring attention to the Emergency Department is evidenced by the Emergency Department discharge documentation. No documented evidence of follow-up treatment is recorded in care plan. This is an area previously identified as requiring action and has not been addressed. |

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| No plan exists for the management of behaviour despite complex interventions (observed) occurring to manage disruptive outbursts, and promote the comfort of all concerned. The plan identifies the resident has a catheter. This has since been removed though the care plan does not mention this. A recent fall resulting in a laceration requiring attention to the Emergency Department is evidenced by the Emergency Department discharge documentation. No documented evidence of follow-up treatment is recorded in care plan. |
| **Finding:** |
| Service delivery plans do not describe the required support and / or intervention to achieve the desired outcomes. |
| **Corrective Action:** |
| Service delivery plans describe the required support and / or intervention to achieve the desired outcomes. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.6: Service Delivery/Interventions **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Care plans are not documented and/or have not been updated (refer 1.3.3.3 and 1.3.5.2). The provision of service / interventions is not consistent with meeting the residents’ assessed needs or desired outcomes. This is an area identified as requiring improvement.  Initial admission assessment and documentation sighted in two of three hospital files and one of two rest home files is undertaken by the previous clinical co-ordinator (RN). These assessments and care plans are last updated in June 2013. Care implemented in these care plans identifies interventions reflective of current good practice.  The recently appointed Care Manager, reports that residents have no specific RN appointed to them, to manage the regular reviews and updates of the residents care plan, though she is managing the process to ensure this happens. One of three hospital and one of two rest home residents recently admitted have no initial care plan completed within 24 hours of admission. The full care plan is not developed within three weeks of admission. The care plans of two of three hospital and one of one rest home resident has not been evaluated within the last six months.  There are appropriate links developed with other services. In two of two rest home and three of three hospital files reviewed referrals sighted include NASC services, mental health services, emergency department and hospital outpatient services. The interview with the GP contacted to provide medical services to Sunhaven verifies satisfaction with the service and enthusiasm in working with the newly appointed Care Manager. One of one family member and one of one resident and sighted customer satisfaction surveys confirm service provided meets assessed need and desired outcome. |

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Care plans are not documented or have not been updated (refer 1.3.3.3 and 1.3.5.2). Provision of service / interventions are not consistent with meeting the residents’ assessed needs or desired outcomes. |
| **Finding:** |
| Interventions are not consistent with meeting the residents’ assessed need and desired outcomes. |
| **Corrective Action:** |
| Interventions are consistent with meeting the residents’ assessed need and desired outcomes. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The activities person at Sunhaven has left and a new candidate is unable to start until the end of January. Daily entertainment has been organised, with outside agencies coming in and providing entertainment, as observed the day of audit. There is no identified documented planned activities programme operating at this time, though a caregiver is in the lounge and instigates activities she is aware residents may like. One of one rest home file and one of three hospital files reviewed have no documented activities assessment completed, while one of one rest home and two of three hospital files has activities assessments with no reviews in the past six months. This is an area identified as requiring improvement.  The plan is to employ an activities person every day of the week, 1pm-6pm. On some days there will be an activities person assistant to help. |

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is no identified documented planned activities programme operating at the time of audit. One of one rest home file and one of three hospital files reviewed have no documented activities assessment completed, while one of one rest home and two of three hospital files have activities assessments with no reviews in the past six months. |
| **Finding:** |
| Activities are not planned to develop and maintain strengths that are meaningful to the resident. |
| **Corrective Action:** |
| Activities are planned to develop and maintain strengths that are meaningful to the resident. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.8: Evaluation **(**HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Two of three hospital and one of two rest home care plans have no documented evidence of being evaluated in the last six months or as needs change.(refer 1.3.3.3) This is an area identified as requiring action.  Evaluation of residents care is documented on a daily basis and is evidenced in progress notes. Any change in a resident’s condition is reported to the RN, as verified by interview with two of two car givers and evidenced by documentation in progress notes. Families are kept informed as verified by interviews with one of one family member, one of one resident, the Care Manager and RN.  Ten of ten medication charts have no documentation to support a three monthly review. Medical reviews are undertaken three monthly (Refer 1.3.3.3). If a resident is not responding to the services being delivered, this is discussed with the GP and changes made. This is evidenced in progress notes (rather than in care plans), and verified by interview with Care Manager and RN. |

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Care plans in place, have not been evaluated for at least six months or as needs change. (refer 1.3.5.2) |
| **Finding:** |
| Evaluations are not documented or are not reviewed six monthly or as needs change. |
| **Corrective Action:** |
| Ensure evaluations are documented and indicate the degree of achievement related to the desired goal. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.12: Medicine Management **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

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| **Attainment and Risk:** PA High |
| **Evidence:** |
| Medicines are prescribed by a medical practitioner and administered by RNs assessed as competent in medicine administration. All medicines are stored in a locked cupboard, in a locked room. There are daily recordings of medicine fridge temperatures which range from 2-5 degree Celsius. Unused or expired drugs are returned to the pharmacy for disposal. Controlled drugs are stored in a locked safe, in a locked cupboard in a locked room. Controlled drugs are audited by the pharmacist six monthly.  Staff are aware of their responsibilities in relation to drug errors. The self-administration of medication at Sunhaven does not occur. All residents' allergies are noted and residents are identified by photographs. 10 of 10 medication records are reviewed, all residents have up to date photographs for identification and those with allergies are identified. Medicine reconciliation is undertaken by the Registered Nurse when the new robotic rolls are delivered each month or as medications change. Registered Nurses administer all medications at Sunhaven.   The RN observed in administering medication has a clear understanding of her responsibilities. The drugs in the pack are checked against the medication chart before being administered to the right resident. Residents are supervised to take their medication. A previous CAR requirement relating to the RNs competency to administer medication has been addressed. The RN administering the medication has been assessed as competent to do so. All registered nurses have their competencies to administer medication reviewed yearly by the pharmacist. This process is to be reviewed to comply with ‘the medicine care guidelines’.   Seven of 10 medication records sighted contain adequate detail to comply with legislation and guidelines. As per a previous CAR, two of 10 medication charts, have a medication request not yet signed by the GP, although the pharmacy has dispensed the medication based on a prescription received. This is an area that continues to require attention.  One of 10 medication records has a warfarin dose being administered that is not documented as reviewed on the date requested. A blood test result is not evident and a review of warfarin dose not recorded. This is brought to the Care Managers attention. The blood result form is consequently sighted; the result is in the normal range. A documented medical review of the blood result is not evidenced. The care manager contacts the laboratory, who had forwarded the results to the residents old GP. The new GP is unaware of the blood results. The new GP is contacted and documentation provided to support Warfarin dose. The dose is sighted to remain as documented on the present medication chart, until next blood test due. Laboratory informed of change in GP. An incident form is documented by the care manager to investigate the exposed risk. A break down in the process enabling safe medication management at Sunhaven is identified by the care manager. RNs have medication competencies reviewed, yet the date of the Warfarin dose review has not been noted at each drug administration. This is an area requiring attention.  All other medication requests are legible and signed by the GP. Stop dates for short term medications are shown and signed off. 10 of 10 medicine records reviewed show no documentation of a review of the resident's medication three monthly. This is an area requiring attention. Medication charts have signature verifications. The pharmacist is available for assistance and advice if required, and will supply information related to residents' medications. A previous CAR related to standing orders not meeting best practice guidelines has been addressed. Standing orders are not used at Sunhaven. Residents have only those medications prescribed by a GP administered to them. |

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

The facilitation of safe self-administration of medicines by consumers where appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

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| **Attainment and Risk:** PA High |
| **Evidence:** |
| As per a previous CAR, two of 10 medication charts, have a medication request not yet signed by the GP, although the pharmacy has dispensed the medication based on a prescription received. This is an area that continues to require attention.   One of 10 medication records has a warfarin dose being administered that is not documented as reviewed on the date requested. A blood test result is not evident and a review of warfarin dose not recorded. This is brought to the Care Managers attention. The blood result form is consequently sighted; the result is in the normal range. A documented medical review of the blood result is not evidenced. The care manager contacts the laboratory, who had forwarded the results to the residents old GP. The new GP is unaware of the blood results. The new GP is contacted and documentation provided to support Warfarin dose. The dose is sighted to remain as documented on the present medication chart, until next blood test due. Laboratory informed of change in GP. An incident form is documented by the care manager to investigate the exposed risk. A break down in the process enabling safe medication management at Sunhaven is identified by the care manager. RNs have medication competencies reviewed, yet the date of the Warfarin dose review has not been noted at each drug administration. This is an area requiring attention.  10 of 10 medicine records reviewed show no documentation of a review of the residents’ medications three monthly. This is also an area requiring attention. |
| **Finding:** |
| Medication requests do not always have written authorisation from the resident’s GP. |
| **Corrective Action:** |
| Medication management documentation is to comply with legislation and guidelines. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' personal preferences are recorded on a white board in the kitchen. Alternatives are always available. One of one rest home resident and one of one relative confirms food is of a high standard. Equipment sighted includes modified cutlery, lip plates, straws, sipper cups and various plate sizes.   A new recent initiative implemented, records on a white board in the dining room, whether the resident has received three components of a meal (eg, breakfast = porridge, toast and a drink). After each meal, residents that have not eaten can be immediately identified, and given finger foods and meal supplements. The goal is to address reduction in food intake before it is reflected in weight loss.  The kitchen is clean and well equipped. Kitchen staff are dressed appropriately. Food stocks are rotated to ensure older stocks are used first. Bread and milk is delivered Monday, Wednesday and Friday, eggs delivered Wednesday, Meat weekly and fruit and vegetables Monday and Wednesday. Meat is stored in large plastic containers to prevent blood seepage contaminating other foods in the event of chiller malfunction. A cleaning schedule is sighted. Dishwasher temperatures and chemical use to achieve optimum results is managed by an outside contractor. Temperatures are recorded daily for freezer, fridge and the chiller. There is adequate hand washing facilities for kitchen staff. Kitchen staff attend training in infection control. |

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

#### Standard 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Sunhaven has a current building warrant of fitness (BWOF) which expires on 22 August 2014. There are appropriate fire alarm and fire suppression equipment, health and safety systems and plans to ensure that the environment is accessible and fit for use by the residents.   During the audit residents are observed moving around the environment independently, with or without mobility equipment depending on their individual needs. Bathrooms, toilets, bedrooms, the lounges and dining rooms are accessible.   Sunhaven provides both dementia care and psychogeriatric hospital level care to 35 residents (34 on the day of the audit). The facility is one large facility with four wings. There is no physical separation within the buildings for dementia and psychogeriatric residents. The owner of Sunhaven has been directed to remodel the facility so that there is a ‘split’ and is required to have this completed by mid-2016.   Reviewed with the owner during the audit are architectural plans dated April and May 2013. Consent was given for the proposed changes to the facility by the local Council on 4 August 2011. Currently the owner reports that he is gaining quotes for materials and fittings. It is planned that the first stage of these changes (referred to as a mini-split by the owner) will commence during 2014.   Previous areas for improvement have been addressed and closed by the Taranaki District health board (TDHB) portfolio manager. These were confirmed during the audit. These are:  1.4.7.1 – the organisation’s emergency planning manual now includes a pandemic plan (13 January 2014) which is aligned with the TDHB’s pandemic plan for the region;  1.4.7.4 – There is now a 2500 litre water storage tank on the property to provide emergency water supplies, and a gas fired barbeque kept in the storage shed on site, to provide onsite cooking facilities.   ARC and ARHSS contract requirements are met. |

#### Standard 1.4.7: Essential, Emergency, And Security Systems **(**HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Two previous areas for improvement were identified for Sunhaven. These related to emergency water supplies and alternative cooking facilities should main supplied fail, and having a pandemic plan. These two findings are now addressed.   Pandemic planning is now included in the organisation’s emergency management manual. This is written to align with the provisions of TDHB and is consistent with current guidelines on managing a pandemic. A copy of the plan was reviewed with the FM during the audit. This topic is now included in emergency planning / response training provided at Sunhaven.   The owner has installed a 2500 litre water storage tank on the property. This is always full, and is currently from the main water supply. Water is recycled through the existing plumbing systems so there is always ‘fresh ‘water in the tank. A gas fired barbeque has been purchased and there are two 9 litre gas bottles. All are stored in the separate shed at the back of the property. . |

##### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation has a policy and procedure to guide staff in the use of restraints and enablers, when they are needed by residents. Most residents are mobile, either with or without assistance.   An interview with the restraint coordinator, who is a fulltime RN, confirmed that equipment used by residents is voluntarily and independently used. She confirms that the training provided to staff includes that the use of enablers is voluntary. The restraint coordinator reports that those residents who use walkers, walking frames or walking sticks do so intermittently and all are fully independent in their use. They do not categorise these aids as enablers because the residents may choose to use their equipment, or not, on any given day and their use is not consistent.   During the audit several residents were observed using walking aids within the facility. They were able to do this without assistance from staff members and this promoted their independence.   Previous areas for improvement were identified in relation to restraint minimisation at certification in 2012. These have been closed by the TDHB portfolio manager and this is confirmed during this surveillance audit. The area for improvement in relation to this standard is 2.1.1.1. The organisation’s policy and procedure now includes the process for assessment and evaluation of enablers. This was reviewed on site and discussed with the restraint coordinator and CM. It is consistent with this standard.   ARC and ARHSS contract requirements are met. |

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.1: Restraint approval and processes **(**HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Two previous areas for improvement were identified against this standard. They are 2.2.1.2 and 2.2.1.3.   The policy and procedure now includes those restraints which are approved for use at Sunhaven. The restraint coordinator and CM described the approval process used at Sunhaven and those restraints which are approved for use when needed.   The restraint approval group met in July to review the use of restraints in the six months January to June 2013 and to review the approved restraints of the organisation. The next scheduled meeting for the approval group is 31 January 2014.  Training for staff members in the organisation’s policy and procedure on restraint use is current. Training has been delivered by the restraint coordinator on 25 June 2013.   ARC and ARHSS contract requirements are met. |

#### Standard 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A previous area of improvement against this standard was identified with staff members not having a current record of education in relation to the use of restraint.   A sample of ten staff files were reviewed during the onsite audit. This sample included four staff members who commenced work in late 2013 and whose induction has included the use of restraints. These four staff are not yet due to have attended the annual restraint minimisation and safe practice training but the content of induction training is adequate for them given that there are currently no restraints in use at Sunhaven. The other six staff members’ files and training records, indicate that they have completed training and have a current competency assessment.   Files sampled (five) indicate that there are no restraints in use currently and interviews with the restraint coordinator and CM confirm this. Staff and CQI meeting minutes record restraint use as a regular agenda item and that there has been no use of restraints at Sunhaven through 2013 and to date.    There are processes to monitor any restraint use which meet the requirements of the standard and are known and understood by the staff members interviewed. There is a restraint register maintained which records restraint use in the past and is consistent with the meeting minutes in there being no restraints in use for at least the last 12 months.   ARC and ARHSS contract requirements are met. |

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Surveillance methodology is outlined in the infection control programme at Sunhaven.  Surveillance data, for all eye, urinary tract, respiratory tract, skin and soft tissue infections is collected monthly by the Care Manager who is the infection control nurse.  All staff at Sunhaven are responsible for reporting suspected infections and the infection control nurse is responsible for ensuring appropriate action, notification and follow-up occurs.  Surveillance results are used to identify infections or events that are relevant to Sunhaven home and hospital. If infection rates are higher than expected, recommendations are made and action plans developed to lower the rates. Surveillance results are also used to identify residents at risk. If data indicates an increase in infection activity, analysis occurs to determine a cause and corrective actions put in place, to prevent reoccurrence. Any immediate actions needed are presented at duty handovers.  Data is graphed and available to all staff in the staff room. Data is reported at monthly CQI meetings and to staff at bi-monthly staff meetings. Education in infection control has occurred within the last year, as evidenced by education records and verified by four of four staff interviews. |

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |