# Bima Health Limited

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Bima Health Limited

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

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

**Dates of audit:** Start date: 2 December 2014 End date: 3 December 2014

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 32

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Sunhaven Rest Home & Private Hospital (Sunhaven) offers dementia and psychogeriatric care for up to 37 residents. As the service was currently undertaking environmental upgrades only 32 beds were available for use and these were all occupied at the time of audit, with 12 residents receiving dementia care and 20 receiving psychogeriatric care. The facility is privately owned and operated by a husband and wife team who both work in the facility.

All areas identified for improvement in the previous audit have been fully addressed by the provider. There were two areas identified as requiring improvement at this audit; one related to restraint minimisation and the other to planning of activities. The requirements of the provider’s agreement with the district health board were met.

## Consumer rights

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

Care provided to residents at Sunhaven was in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy were respected.

Sunhaven supports residents who identify as Maori and had appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided.

Residents felt safe, there was no sign of harassment or discrimination, staff communicated effectively and residents were kept up to date with information. Residents, or their enduring power of attorney, signed a consent form on entry to the service with separate consents obtained for specific events.

Sunhaven informed residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encouraged residents and their enduring power of attorneys to maintain connections with family, friends and their community and encouraged people to access as many community opportunities as possible.

The service had a documented complaints management system which was implemented. There were no outstanding complaints at the time of audit.

## Organisational management

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

The organisation's values, goals and mission statement have been identified in the business plan. This document identified how services were planned and coordinated to meet residents’ needs.

The quality and risk plan showed the measures taken to deliver services in a safe and effective manner. The service implemented corrective action planning to manage any areas of concern or deficits found. Quality management reviews included internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results were shared among all staff and with residents, as appropriate.

The day to day operation of the facility was undertaken by staff that were appropriately experienced, educated and qualified. This allowed residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whānau interviews and in the 2014 satisfaction survey results.

The service implemented the documented staffing levels and skill mix to ensure contractual requirements were met. Human resources management processes implemented identified good practice and met legislative requirements.

Residents’ information was accurately recorded, and all information was securely stored and not accessible to the public. Service providers used up to date and relevant residents’ records.

## Continuum of service delivery

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

Information packs and web sites for Sunhaven contained information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation worked closely with the Needs Assessment Co-ordination Service to ensure access to the service was efficient, whenever there was a vacancy.

There was evidence that residents’ needs were assessed on admission by the multidisciplinary team. All residents’ file sighted provided evidence that needs, goals and outcomes were identified and reviewed on a regular basis with the resident, and where appropriate their family. Residents and families interviewed reported the care provided at Sunhaven was of a high standard.

An activities programme, that included a wide range of activities and involvement with the wider community, was enjoyed by residents; however, planned activities did not always meet the resident’s needs and activity levels as identified in the activities assessment, and this requires improvement.

Well defined medicine policies and procedures guided practice. Practices sighted were consistent with these documents.

The menu has been reviewed as meeting nutritional guidelines by a registered dietician, with any special dietary requirements and need for feeding assistance or modified equipment recorded and met. Residents had access to food at any time and had a role in menu choice. Interviews with residents verified satisfaction with meals.

## Safe and appropriate environment

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

There were documented emergency management response processes which were understood and implemented by the service providers. This included protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building had a current building warrant of fitness and the service had an approved fire evacuation plan.

The upgrade to the internal facility in progress, and due for completion by December 2016, will allow for separate areas for dementia residents. The facilities met residents’ needs and provided furnishings and equipment that was regularly maintained. All bedrooms were single occupancy.

There was adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas met residents' relaxation, activity and dining needs.

The facility was centrally heated and ventilated through opening doors and windows. The outdoor areas were secure with furnishings and shade for residents’ use.

## Restraint minimisation and safe practice

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

Policy clearly described that enablers were voluntary and the least restrictive option. The service had 13 residents with enablers, which was an area identified for improvement as residents are unable to give appropriate voluntary consent. There are five residents with bedside rails. Documentation identifies all restraint is well documented. Processes for determining restraint approval and ongoing assessments were implemented to meet policy requirements. Staff have undertaken regular restraint education and were fully versed in safe restraint procedures. Review processes met the requirements of the restraint minimisation standards.

## Infection prevention and control

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

Sunhaven demonstrated it provided a managed environment, which minimised the risk of infection to residents, service providers and visitors. Reporting lines were clearly defined, with the infection control co-ordinator reporting directly to the facility manager who reports to the owner.

There was a clearly defined infection prevention and control programme for which external advice and support was sought. An infection control nurse was responsible for this programme, including education and surveillance.

Infection control policies and procedures were reviewed annually. Infection prevention and control education was included in the staff orientation programme, annual core training and in topical sessions. Residents were supported with infection control information as appropriate.

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections was collated and analysed. Surveillance results were reported through all levels of the organisation, including governance.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Services provided by Sunhaven Rest Home & Private Hospital (Sunhaven) complied with consumer rights legislation. Policy documents, plus the sighted staff orientation programme, in-service training records, planned education programmes, interviews (four residents, six family members and ten staff) and resident/relative satisfaction surveys, verified staffs knowledge of the Code of Health and Disability Services Consumers’ Rights (the Code).  Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy (notes being locked away, confidentiality of information, cordless phone available to make phone calls and staff knocking on residents' doors prior to entering their rooms), and residents were addressed by a preferred name. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The informed consent policy clearly described all procedures to ensure the resident’s rights to be informed of all procedures undertaken. Residents’ choices were respected by the service. Residents at Sunhaven and their enduring power of attorney (EPOA)/families were provided with the information needed to make informed choices and give informed consent.  Admission documentation informed the resident and their EPOA of inclusions and exclusions in service, and requested consent to; collect and retain information, take a photograph for identification purposes, a name on a bedroom door and to travel in transport organised by the service. Residents were able to select their GP of choice. Informed consent was evident in observation of activities at audit, with residents being actively involved in the decision making process.  Files reviewed evidenced informed consent was included in the admission agreement and identified the resident/EPOA, and where desired family/whanau, are informed of changes in residents’ condition and care needs, including medication changes. Residents/families/EPOAs choices and decisions were recorded and acted on. Verbal consent was obtained prior to an intervention being carried out as observed and verified in clinical staff, resident and family interviews. Care plans were reviewed and signed by the residents’ EPOA or family/whanau, where appropriate, to say they had read and agreed with what was written.  Staff education on consent takes place during orientation and in-service training sessions. Staff interviews verified understanding of the informed consent process, resident's right to privacy, to be treated with respect and dignity, to be fully informed of all care procedures and the resident's right to decline to consent at any time.  Interviews confirmed the necessary information was provided for residents to make informed choices and choices were respected by staff. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Sunhaven recognised and facilitated the rights of residents and their EPOA/family to advocacy/support by persons of their choice. Residents received information on the Nationwide Health and Disability Advocacy Service and on admission were advised of their right to contact the Health and Disability Commissioner’s office if they felt their rights had been breached. Advocacy information was observed in brochure format in the facility. The facility had open visiting hours. Residents’ families were free to access community services of their choice and Sunhaven utilised appropriate community resources, both internally and externally. Residents and their families were aware of their right to have support persons, as verified in staff, residents and family interviews. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents of Sunhaven were assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of Sunhaven. The service acknowledged values and encouraged the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement and accesses community resources.  Resident and family interviews confirmed visitors visit freely and assistance was provided to access community services. Visitors were observed coming and going from the facility during the audit. File reviews, residents, families, facility manager, registered nurse, care assistants and the activities officers interviewed described a range of community services used by the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints management was implemented to meet the sighted policy requirements. As confirmed during staff and family/whānau interviews, complaints management was explained during the admission process. Management’s open door policy made it easy to discuss concerns at any time. All complaints were documented and followed up by the facility manager as shown in the complaints register sighted.  Staff confirmed during interview that they understood and implemented the complaints process for written and verbal complaints that occur. The facility manager used the information to improve services as appropriate. This process was identified in the corrective actions follow up documented. There were no outstanding complaints at the time of audit. The one complaint sighted since the previous audit was of a minor nature. Compliments sighted showed that family/whānau members have noticed very positive changes to care delivery over the past seven months. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Interviews with residents and families of Sunhaven verified they were informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service were displayed and accessible to residents.  Residents/families/EPOAs received a copy of the Code in the admission information pack. Discussion, clarification and explanation on the Code and the Nationwide Health and Disability Advocacy service occur at this time. Legal advice is able to be sought on the admission agreement or any aspect of the service.  Access to interpreters was available. The Nationwide Health and Disability Advocacy service provided onsite training and an advocate was accessible at any time. Compliance with the standard was verified by, observation, documentation and interviews. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Policy identified procedures were in place to prevent abuse and neglect. Procedures to ensure resident privacy and dignity were also in place and identified actions taken to meet residents’ needs. This included spirituality and sexuality and clear management strategies for caregivers.  Residents received services from Sunhaven which treated them with respect, had regard for their dignity, privacy and independence and was responsive to their needs values and beliefs. All bedrooms occupied on the days of audit were single occupancy, enabling privacy for discussion, and of a size that allowed appropriate storage of personal belongings. Staff were observed to close doors when undertaking personal cares and discussions. Locks were on toilet and bathroom doors. The nurses’ station was accessed via a key and provided privacy of stored information. Staff education on privacy takes place at orientation and during in-service education.  Residents’ needs, goals, likes and dislikes were identified in the care plan. Interventions identify the assistance the resident required to maintain dignity and respect and to ensure sexuality, spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.  Residents were kept free from discrimination, harassment and abuse. The individual employment agreement, Code of Conduct, job description and company policies and procedures identified the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse.  Interviews verified there were no concerns expressed related to abuse or neglect.  Residents had access to visitors of their choice and were supported to access community services. The environment enhances and encourages choice, opportunity, decision making, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives.  Staff of Sunhaven demonstrated responsiveness to residents’ needs. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Documentation was in place to guide staff practices to ensure residents’ needs were met in a manner that respected and acknowledged their individual and cultural, values and beliefs. Policy stated that this was to be identified upon entry as part of a resident’s care planning process. Whanau relationships and involvement in care were recognised. The privacy policy and residents’ rights were printed in English and te reo Maori. The organisation had a documented Maori Health Action Plan which identified their priorities related to culturally safe services.  Sunhaven recognised the relationship between iwi and the Crown, and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). Residents who identified as Maori had a plan of care in place which supported the resident’s cultural needs. An interview with a resident and their family verified values and beliefs were acknowledged, respected and met by the staff.  The local iwi supports Sunhaven in meeting the needs of Maori residents. Staff receive education in relation to cultural safety and the Treaty of Waitangi. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Policy identified that residents will receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs.  Residents of Sunhaven received culturally safe services which recognise and respect ethnic, cultural and spiritual values and beliefs. Resident’s and/or family/whanau interviewed verified residents were consulted about individual values and beliefs. Residents’ specific cultural, spiritual, values and beliefs were documented in the care plan, to ensure residents’ needs and objectives were attended to.  Clergy of all denominations visit regularly and a multi-denominational roster of church service was sighted in the activities programme. Residents access spiritual support from the community if required. Open visiting policy allowed family/whanau to visit when able.  Evidence to support findings was observed and sighted in file reviews and staff training records. Resident and family/whanau interviews confirmed care provided met residents’ needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policy indicated that residents were to be free from all forms of discrimination, coercion, harassment and exploitations.  Residents, families and staff interviewed verified that residents of Sunhaven were free of any discrimination, coercion, harassment, sexual, financial or other exploitation. Residents/families/EPOAs felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination. Staff communicated effectively and residents and family members were kept up to date.  Orientation/induction processes informed staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provided clear guidelines on professional boundaries and conduct, and informed staff about working within their professional boundaries. A signature acknowledging the terms related to this information was located in all employment agreements. The manager has the responsibility to action formal disciplinary procedure if there was an employee breach of conduct.  The above was evidenced in staff files and verified in staff, resident and family interviews. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Sunhaven provided an environment that encouraged good practice. Policies sighted were current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies were reflective of current up to date practices, which were monitored and evaluated at organisational and facility level.  Human resources were managed to employ competent employees. New employees completed a comprehensive orientation/induction programme that was relevant to the role they were undertaking. Staff records evidenced competent employment practices, orientation and training records.  Care staff were trained or undertaking ‘Aged and Dementia care training’, in addition to training in managing challenging behaviours and de-escalation strategies. Observations verified staffs had appropriate skills. Registered nurses’ on-going education was supported by the District Health Board and the specialist services that they operate. Sunhaven has subscribed to an on-line training programme in addition to offering an in-service education programme, which was monitored to ensure the key components of service delivery were covered to meet contractual requirements and residents' need. Staff interviewed, confirmed the orientation/induction education and training prepared them for their roles. Staff stated they were encouraged and supported to undertake education that assists in their roles.  The registered nurses who administer medication had yearly assessments to determine competency, in addition to current first aid certificates. Senior caregivers were assessed in their competency to check drugs that required two persons to check. The trainee diversional therapist who provided activities and outings for the residents, had a current first aid certificate. Kitchen staff were qualified in Safe Food Handling.  Interviews and resident satisfaction surveys indicated satisfaction with the service, as did an interview with a general practitioner (GP). The GP confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policy identified that interpreter services were available and offered to residents with English as a second language.  Residents and family interviews confirmed communication with staff at Sunhaven was open and effective. Residents/families/EPOAs were consulted and informed of any untoward event or change in care provision and included in care reviews, as sighted in files reviewed. A recent relative satisfaction survey identified two family members had commented they were not sure who to take specific concerns to. The corrective action identified to resolve this concern was evidenced to be in place and effective.  Sunhaven had an open disclosure policy which guided staff around the principles and practice of open disclosure. Education on open disclosure was provided at orientation and as part of the annual education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with relatives was documented in the residents’ communication records. Incident forms evidenced families being informed when incidents occurred.  No residents at Sunhaven required interpreting services; however, management was aware of how to access interpreters if this service was required.  Staff were observed introduced themselves to residents upon entering the resident's room and staff were identifiable by their name badge. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The description of the company shown in the business plan identified that the proprietor/director was responsible for the overall management of the facility. He is supported by his wife who is the co-owner of the facility and the facility manager who was in charge of the day to day running of the facility. The clinical team included two clinical nurse managers (CNMs) who job share the role. All members of the management team had job descriptions which identified their experience, education, authority, accountability and responsibility for the provision of services.  The organisation’s philosophy, vision, mission statement and goals were clearly described in the business plan for 2014-2015. The business plan identified that it was working towards the goal of separating the care environment for both the dementia and psychogeriatric residents which was expected to be completed in 2016.  A formalised monthly meeting was held with the proprietor/director and facility manager to discuss any issues that arise and reviewed ongoing progress to meet business plan goals.  Interviews with residents and family/whānau confirmed that their needs were met by the service. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The business plan outlined how the day to day operation of the service was managed and identified the reporting lines for staff to ensure the provision of services were offered to meet residents’ needs.  During a temporary absence of the proprietor/director the role was undertaken by the facility manager and vice versa. The CNMs covered each other for planned leave and sick leave and shared the on-call component of the job. This ensured the services were managed in an efficient and effective manner to meet residents’ needs. Service satisfaction was reported during resident and family/whānau interviews and by the results sighted for the 2014 resident and family/whānau satisfaction survey. |
| 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. | FA | The organisation had a documented quality and risk management plan which identified risks and showed the strategies in place to manage risks. The business plan showed that all issues were discussed at staff and management meetings and that the proprietor/director was kept fully informed. Any issues are discussed at staff and management meetings and that the proprietor/director is kept fully informed. Quality data collection and analysis was maintained by the service and evaluation of results shared with staff and management. Quality improvements were put in place where indicated. This is confirmed in minutes sighted. One example related to the update and improvement of resident care plans which had been signed off as completed. The review of 11 residents’ care plans confirm all the update to files.  All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. The document control system ensured that obsolete documents were removed from use.  Regular audits were undertaken and corrective action planning was put in place to manage any deficits found. Staff confirmed that all follow up actions were discussed during handover and at regular staff meetings. Data was collected, trended, reviewed and evaluated for all key components of service (complaints, incidents and accidents, health and safety, hazards, restraint and infection control). Occupational safety and health practices were described in policy implemented and included staff training and education.  Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management.  Actual and potential risks were identified and documented in the hazard register. Newly found hazards were communicated to staff and residents as appropriate. Staff confirmed during interview that they understood and implemented documented hazard identification processes. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Incident reporting as described in policy was implemented by the service. This included the provider’s statutory obligation related to essential notification reporting. Members of the management team verbalised their understanding of this reporting process.  All adverse, unplanned or untoward events were recorded, reported and analysed. Information was used as an opportunity to improve services where indicated. If the service had any concerns related to a resident this information was shared in an open and honest manner with family/whānau as appropriate to ensure open disclosure was maintained. A review of the 2014 incident and accident forms showed that family/whānau had been notified of incidents, accidents, adverse events or concerns in a timely manner. This was confirmed during six family/whānau interviews. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Staff that required professional qualifications have them validated as part of the employment process and ongoing annually as confirmed in documentation sighted for six RNs, two GPs, one podiatrist and seven pharmacists. All caregivers had either completed all or part of recognised aged care qualifications, including dementia care (the ‘ACE’ programme).  Policies and procedures implemented identified that good employment practice and legislative requirements were met. This was confirmed in the seven staff files reviewed Signed job descriptions and employment contracts were sighted in all files.  The staff have completed an orientation programme with specific competencies for their roles, as sighted in the staff files reviewed. Staff ongoing education covered all areas of service provision, with a special focus on behaviour management, and was clearly documented under each staff member’s name. The annual in-service education calendar and off-site education undertaken by staff was related to the roles they undertake. Staff appraisals were up to date and all RNs and most caregivers held current first aid certificates.  Interviews with four residents and six family/whānau members along with the 2014 satisfaction survey results identified that residents’ needs were met by the service. No negative comments were voiced on the days of audit. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The organisation had a clearly documented process to determine staffing requirements which is implemented. This is confirmed by a review of six weeks of staffing rosters. Staff are replaced for sick leave and annual leave and if additional staff are required to manage any clinical situation.  Staff who undertake two roles such as activities coordinator and/or caregiving have two job descriptions in their files. Staff confirmed during interview that they had enough time on all shifts to meet residents’ needs.  There is a RN on duty to cover all shifts. Dedicated staff undertake cleaning, laundry and kitchen duties seven days a week. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information, which included relevant assessment and medical information, was received prior to a resident’s admission to Sunhaven. This information was used to develop individual resident’s files. Residents had additional information relevant to their circumstances recorded on the day of admission and always within 24 hours of admission.  The residents' records contained legible and dated information with the time of entry and the designation of the staff member. A daily progress notes records the daily cares the resident had received. Integrated notes on the resident's progress were completed by care staff daily and by the registered nurse where RN input was required. A ‘sign off’ by the GP that the resident was stable and only required three monthly visits was made each visit as sighted in files reviewed.  All records sighted were securely stored in a locked office. Archived files were in a locked room, and easily accessible.  Residents’ information was kept in hard copy format. The facility manager kept a register of all necessary details of past and present residents. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Prior to accessing the services of Sunhaven, the residents have been assessed by the Needs Assessment and Service Co-ordination (NASC) agency, to ensure there was a requirement for psychogeriatric hospital or dementia level rest home care. When the need for service had been identified, it was planned, co-ordinated and delivered in a timely and appropriate manner. If a phone enquiry was received from someone who had not been assessed by the NASC, they were advised to contact their GP or the local NASC agency.  Information about the service included full details of the services provided, its location and hours, how the service was accessed and identified the process if a resident required a change in the care provided.  If the family chooses Sunhaven as the appropriate place to provide service, a planned admission process is commenced. The admission agreement was provided, enabling an opportunity to seek guidance/legal advice. As Sunhaven is an integrated unit (whereby the dementia and hospital unit operates as one) consent was obtained on admission, acknowledging acceptance of this arrangement. (Refer Standard 1.2.1 re changes underway)  Files reviewed contained completed assessments. Signed admission agreements met contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer was managed in a planned and co-ordinated manner, with an escort. The resident family/whanau was fully informed. There was open communication between all services, the resident and the family. At the time of transition appropriate information was supplied to the person/facility responsible for the ongoing management of the resident. There was a specific transfer/discharge form that recorded all the relevant information needed when transferring a resident. If the resident was transferring to a DHB or another facility, a verbal handover was given. All referrals were clearly documented in the progress notes. Evidence was sighted in files reviewed and verified by interviews. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Policy and procedure described current good practice related to medicine management. This included prescribing, dispensing, administration, review, storage, disposal and reconciliation processes.  Medicines for residents were received from the pharmacy in the robotic delivery system. A safe system for medicine management was observed on the day of audit. All staff who administered medicines had current medication competencies. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Eye drops were dated when opened and fortnightly checks of medications for expiry dates was sighted.  Controlled drugs when in use were stored in a separate locked cupboard. Controlled drugs, when administered were checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly stock checks and accurate records.  The records of temperatures for the medicine fridge had readings documenting temperatures within the recommended range.  The medicine prescription was signed individually by the GP. The GP’s signature and date was recorded on the commencement and discontinuation of medicines. Residents’ photos, allergies and sensitivities were recorded on the medicine chart. Sample signatures were documented. All medicine charts reviewed had fully completed medicine prescriptions and had signing sheets including approved abbreviations when a medicine had not been given. The three monthly GP review was recorded on the medicine chart.  Medication errors were reported to the clinical coordinators and recorded on an incident form. Incident forms recording drug errors were few and evidenced errors managed appropriately. The resident and/or the designated representative were advised.  Standing orders were used by Sunhaven. The written authorisation was signed by the resident’s GP, and identified the directions and indications for each medicines use. The standing order specified the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food, fluid and nutritional requirements of the residents at Sunhaven was provided in line with recognised nutritional and food safety guidelines.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen was monitored by an external provider. The facility received monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance.  There is evidence to support sufficient food was ordered and prepared to meet the resident’s recommended nutritional requirements. Between meal snacks were available at all times as sighted and verified by resident, staff and family/whanau interviewed.  A dietary assessment was undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements were known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, was sighted. At meal times a documented record was kept of how much each resident eats to enable extras to be offered when the resident had not eaten enough to avoid weight loss.  Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews and sighted satisfaction surveys.  There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed. The dining rooms were clean, warm, light and airy to enhance the eating experience  When food was delivered it was checked for the ‘use by date’ and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures were monitored daily. Records sighted verified records were within accepted parameters.  Raw meat was stored at the bottom of the fridge and was completely thawed before cooking. Dry stock was decanted into large bins after the bins have been washed. All containers were dated, when decanted. Evidence was sighted of stock rotation. Any leftovers were covered and labelled with the date/time/contents. Leftovers were not reheated more than once and were discarded if older than two days. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | An interview with the facility manager verified a process existed for informing residents, their family/whanau and their referrers if entry was declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. Reasons for declining entry in the past were related to Sunhaven not offering the services the resident required. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | There were policies, procedures and recognised assessment tools (such as the Braden Scale for pressure area risk) for all aspects of clinical care available for staff use when assessing a resident’s needs. Resident falls risk was ascertained upon entry to the facility and updated three monthly or more often if required.  The registered nurse (RN) had assessed the residents within 24 hours of admission, gathering data from the resident, their family/nominated representative, the needs co-ordination services assessment and previous provider’s care services to the resident. In addition to this, data was gathered from a range of clinical assessments carried out by the RN. Within three weeks a long term care plan, based on the collection of more comprehensive assessment data, was developed. The plan directed the ongoing care required to meet the resident’s needs and desired outcome. Resident’s ongoing assessments, review and evaluations were completed and documented by the RN every six months or as a resident’s need changed, in consultation with the resident, family and allied professionals. Sunhaven was not using the interRai assessment tool at this time. A medical assessment was conducted by the resident’s general practitioner (GP) of choice, within 24 hours of admission, and the medical treatment programme required by the resident was documented. Ongoing medical and pharmaceutical review were undertaken by the GP either monthly or three monthly if the medical practitioner deemed the resident to be stable. This took place in the privacy of the resident’s bedroom or the whanau room with the resident and/or family/whanau present if requested.  Continual assessment and evaluation of the resident’s behaviour was observed with de-escalation strategies initiated when needed to minimise disruption. Evidence of this was sighted in files reviewed. Resident and family interviews, verified they were included and informed of all assessment updates and changes. Staff interviewed confirmed they used observation and the information in the care plan to deliver the care the resident required. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans at Sunhaven were developed in consultation with the resident and/or family/whanau, and described the required support the resident needed to meet their goals and desired outcomes.  Evidence of the care provided was sighted in files reviewed. Progress notes, activities notes, medical and allied health professionals notations were clearly written, informative and relevant to the care provided. Any change in care required was written down in progress notes and the resident's care plan and verbally passed on to those concerned.  Short term care plans documented the existence of short term problems and the required interventions. The facility was in the process of updating to a more integrated format for its clinical records. Care plans were evaluated six monthly or more frequently as the resident's condition dictated. Resident and family interviews verified they were included in the planning of their care.  The staff education records sighted demonstrated that staff received appropriate training. The RNs participated in the professional development offered by the DHB. Staff were observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility had access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Files reviewed, observations and interviews with staff verified the provision of care provided to residents at Sunhaven was consistent with residents’ physical, social, spiritual, behavioural and emotional needs and desired outcomes. Interventions were detailed, accurate and met current best practice standards.  Interviews with residents and family/whanau members expressed satisfaction with the care provided.  There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the resident’s needs. |
| 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 Low | A planned activities programme was sighted that aimed at facilitating the residents at Sunhaven developing and maintaining their strengths and interests as identified in the activities assessment. However despite the activities programme meeting the assessed activity needs of some residents, this was not always the case.  Individual activity assessments were undertaken by the trainee diversional therapist, updated or reviewed at least three monthly, and there was a monthly summary of the resident’s response to the activities, level of interest, and participation recorded. The goals were developed with the resident and their family, where appropriate.  The activities programme was provided by a trainee diversional therapist with a current first aid certificate and an activities co-ordinator, seven days per week. Photographs around the facility offered insight into the events that have taken place.  Resident and relatives interviewed and satisfaction surveys provided evidence of satisfaction with the activities programme. The activities officer interviewed reported feedback was sought from residents and families during and after activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ care was evaluated daily and reported in the progress notes. If any change was noted this was reported to the RN.  Formal care plan evaluations measuring the degree of a resident’s response in relation to desired outcomes and goals occurred every six months or as a resident’s needs changed and were carried out by the RN. Where progress was different from expected, the service was seen to respond by initiating changes to the service delivery plan.  A short term care plan was initiated for short term concerns such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans were reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.  Evidence of evaluation was sighted in files reviewed. Resident and families interviewed, verified they were included and informed of all care plan updates and changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | If the need for other non-urgent services was indicated or requested, the GP or RN sent a referral to seek specialist service provider assistance from the DHB. Referrals were followed up on a regular basis by the registered nurse or the GP. The resident and the family were kept informed of the referral process. Residents were supported to access other health and/or disability support services, and when possible a family member and a staff member accompanied the resident. Acute/urgent referrals were actioned immediately, sending the resident to accident and emergency in an ambulance, with an escort, if the circumstances dictated. Families were informed, as sighted in files reviewed and verified by interviews. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policy and procedure in the infection control programme identified that all waste was disposed in accordance with infection control practices in order to minimise the risk of contamination though unnecessary exposure. There were no specific territorial authority requirements. There was a documented process for the safe use and disposal of sharps.  Staff followed documented processes to ensure safe and appropriate storage and disposal of waste, infectious or hazardous substances. All chemicals were securely stored and clearly labelled.  Personal protective equipment/clothing (PPE) sighted included disposable gloves and aprons and goggles. Interviews with ten staff and five members of the management team confirmed they can access PPE at any time. Staff were observed wearing disposal gloves and aprons as required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness was issued on the 19 August 2014.  Maintenance was undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurred in November 2014 by a registered electrician. All electrical equipment sighted had an approved testing tag. Clinical equipment, such as oxygen regulators, sit on weigh scales and sphygmomanometers, were tested and calibrated at least annually or when required. This last occurred on 27 December 2013 by an approved provider.  The physical environment minimises the risk of harm and safe mobility by ensuring the flooring was in good condition, bathroom floors were non-slip, the correct use of mobility aids and walking areas were not cluttered. Regular environmental audits sighted identify that the service actively worked to maintain a safe environment for staff and residents.  The refurbishment programme underway to separate the dementia and psychogeriatric services was managed safely with the active building areas being sectioned off and warning signs clearly displayed to prevent unauthorised persons entering the areas. The work is due for completion in December 2016.  There were easily accessed secure outdoor areas for residents. Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There were adequate toilet/shower facilities for residents which were clearly identified with separate staff and visitor facilities. A small repair was carried out on the days of audit for one toilet area to ensure that all infection control cleaning requirements were met.  Hot water temperatures were monitored and documentation identified that they remained within safe levels. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms were single occupancy and of a size which allowed enough space for residents to mobilise with or without assistance in a safe manner. They were personalised to meet resident’s wants and needs and had appropriate areas for residents to place personal belongings. One resident was in a bedroom where a new fire wall has been erected. The wall was not yet plastered. Three staff confirmed that the resident did not want to be moved.  Resident and family/whānau member interviews confirmed they were happy with their bedrooms which allow privacy if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Residents were provided with safe, adequate areas to meet their relaxation, activity and dining needs. There were currently two dining and lounge areas and residents could choose which one they wish to go into. Areas contained comfortable furnishings to meet residents’ needs. Resident and family/whānau voiced their satisfaction with the environment during interviews.  Activities were undertaken in the largest of the lounge areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Policies and procedures identified how the provision of safe and hygienic cleaning and laundry services were to be provided. This included the safe storage of chemicals used.  As observed, PPE was readily available and used appropriately during cleaning processes. Chemicals were clearly labelled and safety data sheets available.  Documentation sighted for laundry and kitchen equipment identified that the provider of chemicals used monitored the chemical usage, washing machine operations and dishwasher cycles for effectiveness.  Staff maintained the cleaning schedule sighted. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency supplies and equipment included food and water should they be required. There were first aid supplies which were kept up to date. The emergency evacuation plan and general principles of evacuation were clearly documented. The service had an approved fire evacuation plan dated 6 November 1995. There have been no changes in the building footprint since then.  Emergency staff education and training, including a trial evacuation was undertaken at least six monthly. This last occurred in November 2014 with no follow actions required. Documentation identified that the service had an agreement with a local company to ensure they will be provided with an emergency generator should a major power outage occur.  There were CCTV cameras in the public areas of the facility monitored from the manager’s office. Staff were required to ensure doors and windows were securely closed at night. This was confirmed during staff interviews.  Call bells were located in all residents’ bedrooms. Resident and family/whānau interviewed confirmed call bells were answered in an acceptable timeframe. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All resident areas had at least one opening window and/or door which provided natural light and ventilation. The facility was heated via central heating which was distributed through ceiling outlets. The facility was warm and well aired on the days of audit. Residents and family/whānau stated that the facility was kept at a suitable temperature throughout the year. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Sunhaven provided a managed environment that minimised the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There was a documented infection control programme that aimed at establishing, maintaining and monitoring procedures covering infection control practices. The programme included actions required by staff, residents and visitors when exposed to infectious diseases. Familiarity with policy was verified through staff, resident and family interviews. It was the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines were clearly defined, as verified in staff interviews. It was the responsibility of the infection control nurse to ensure appropriate resources were available for the effective delivery of the infection control programme and to implement the programme.  The infection control programme was reviewed annually and was last reviewed in November 2014. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The documented infection control programme implemented was appropriate for the size and services offered by the organisation. A position description for the role of the infection control nurse (ICN) was included in the IC programme and in the RN’s personnel file.  The ICN and observation verified there were enough resources to implement the infection control programme. Training records sighted verified the ICN completed a Diploma in infection control and prevention in January 2014.  Implementation of the infection control programme was evidenced through review of data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service education records of infection control training for staff. Any IC concerns were reported at the six weekly quality meeting and monthly staff meetings. IC data was collected monthly and statistics and data were graphed and analysed. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Policies and procedure were reflective of current accepted good practice. They cover all aspects of infection control management including the correct use of personal protective clothing/equipment.  Sunhaven had an IC programme that was reviewed annually, and includes compliance with policies and procedures. These policies were appropriate to the services offered by the facility. Policies were current and signed off by the manager.  Nine clinical staff interviewed described the requirements of standard precautions and could say where the IC policies and procedures were for staff to consult. Cleaning, laundry and kitchen staffs were observed to be compliant with generalised infection control practices. A staff member verified training in IC during orientation. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff received orientation and ongoing education in IC and prevention as verified by staff training records and interviews with staff. The content of the training was documented and evaluated to ensure the content was relevant and understood. A record of attendance was maintained. Audits were undertaken to assess compliance with expectation.  Education for residents occurred in a manner that recognised and met the residents’ and the families’ communication style, as verified by residents, EPOA and family interviews. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | In line with Sunhaven's IC policy, procedures and programme, monthly surveillance was occurring. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month were recorded on an infection report form and graphed. Incidents of infections were sighted and were low. These were collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections were presented at the quality meeting every six weeks and the staff meeting every month.  A yearly comparison based on previous incidents was used as a comparison to analyse trends. Any actions required were presented to staff at staff meetings and any necessary corrective actions discussed, as evidenced by meeting records, IC records and verified by staff interviews.  A recent suspected scabies outbreak was handled promptly and in line with best practice; investigation evidenced it was not scabies. A review and analysis of the process was documented and sighted. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | Policy identified that restraint was used only if required to keep the resident safe. It defined the use of enablers as voluntary and the least restrictive option.  The service had environmental restraint clearly shown in relation to keeping the entrance door locked. (This is not actually required as the level of care offered by the service requires a secure environment for residents).  There were 13 enablers (walking frames or pillows in beds) identified. As residents were unable to make voluntary decisions these items cannot be deemed as enablers and this needs to be reviewed. Assessment identifies that the use of walking frames and placement of pillows in beds was used for resident safety in relation to mobility and pressure area management and was not being used as a restraint as confirmed by staff interviewed and resident file reviews. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval processes were clearly documented. This included clear lines of accountability for restraint use, such as the restraint approval group, and caregiver monitoring when restraint was in use.  The restrain coordinator ensured that the process was followed when seeking approval for a new restraint. Interviews with nine clinical staff confirmed their knowledge and understanding of the restraint approval process and documentation sighted in three restraints reviewed showed all processes were met. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The assessment forms now being used met the requirements of this standard as confirmed in a review of three residents’ files where restraint was being used. As each resident’s three monthly restraint assessment was being reviewed, updated assessment forms were being used. The old assessment forms did not cover all assessment requirements as identified in this standard. The restraint coordinator confirmed that during staff education the correct use of the new forms had been discussed. This was confirmed by two RNs. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | All restraints used must be approved by the restraint committee approval group which was well documented. Monitoring requirements identified that all restraint and enabler use was monitored as describe on each resident’s restraint approval form, depending on the risk factors identified. All restraints were monitored at a minimum of two hourly. There have been no reported incidents or accidents related to restraint use.  A detailed restraint register was kept with sufficient information to provide an auditable record of all restraint use at the facility. This identified start and stop dates for all restraints.  No restraints were put in place until the approval process was complete and alternative interventions have been tried, such as use of a low bed. Family/whānau and the GP were involved in the decision to use bedside rail restraints. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | All episodes of restraint were regularly reviewed at staff and RN meetings. A full evaluation was undertaken three monthly to determine that the restraint was still required to help keep the resident safe. Review dates were shown in the restraint register and on the individual resident’s care plans.  Staff input into the evaluation process indicated if the restraint was adequate and that the resident remained safe. This was confirmed in meeting minutes sighted and during staff interviews.  The restraint coordinator reviewed monitoring processes monthly and ensured the policies and procedures were kept up to date. Staff education included information that allowed staff to manage restraints in a safe manner. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Policy identified that the annual quality review, which occurred in July 2014, included all relevant information and was informed, in part, by the six monthly restraint minimisation audit results.  The review covered staff education content, if the policy and procedures were followed by staff and the numbers of restraints in use including enablers. This report was presented to senior management and staff. Policy and procedures were also reviewed annually to ensure they were reflective of current good practice. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The activities programme at Sunhaven did not address all residents’ activity levels, interests and abilities as identified in the activity assessment. Active residents with very physical interests had no provision made for their abilities and skills levels in the activities offered at Sunhaven. | Activities were not provided to facilitate and maintain strengths of all residents. | Activities are provided to develop and maintain strengths (skills, resources, and interests) that are meaningful to all residents.  180 days |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | The service identified that 13 residents had enablers. These were either walking frames (5) or pillows in residents’ beds to prevent adverse pressure on residents’ joints (8). These were part of the care required for residents who required assistance to walk independently with a frame or who were unable to move around the bed without assistance and had been identified through an approved assessment processes to show that they were at a high risk of developing pressure areas. This does not meet the intended definition of restraint and these need to be reviewed by the restraint committee.  There were five residents with bedside rails which were identified correctly as a restraint. | The service had 13 enablers in use. Residents in the facility were cognitively impaired and not able to make voluntary decisions around options that ensured independence and safety. Therefore the use of enablers needs to be reviewed to ensure the intent of the standard is met. | Reassessment of enablers needs to be undertaken to show if the use of these are voluntary and meet the intent of the restraint minimisation standards.  180 days |

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

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

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

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

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End of the report.