

Sunrise Healthcare Limited - West Harbour Gardens

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Sunrise Healthcare Limited

Premises audited: West Harbour Gardens

Services audited: Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical

Dates of audit: Start date: 4 July 2017 End date: 5 July 2017

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

Total beds occupied across all premises included in the audit on the first day of the audit: 55



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.

General overview of the audit

West Harbour Gardens residential care is part of the TerraNova homes. The service currently provides care for up to 74 residents. The service is certified to provide hospital (medical, geriatric) rest home and residential – disability level care. On the day of the audit, there were 55 residents. Two rooms were being refurbished at the time of audit and were unoccupied.

The facility manager (RN) has many years' experience in aged care management. The clinical coordinator (RN) has been in the role for one year and has worked in aged care for the last four years.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files,

observations and interviews with a GP, residents, family members, staff and management. The prospective owner was interviewed on the first day of the audit.

The prospective provider owns a 40-bed hospital in Auckland. The prospective provider intends to continue with the quality processes as set out in the previous provider's quality plan. The current facility manager and the Terra Nova clinical quality and risk advisor will provide orientation and induction to processes and the clinical coordinator will stay on in charge of the clinical services. The prospective provider (chief executive officer) is a qualified chartered accountant and will oversee financial matters. Reporting processes will stay in place but reports will be to the new directors. The prospective providers' transition plan is to keep all operational processes the same with only the directors changing. The current owners have entered into contractual arrangements where they will provide Vendor Support for 20 working days following completion of the sale and provide core system services for up to 6 months from completion (at the election of the Purchaser) to allow an ordered transition of these services.

One improvement is required around timely completion of InterRAI assessments.

The facility has achieved a continuous improvement around infection control surveillance.

Consumer rights

West Harbour Gardens endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

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

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

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

Continuum of service delivery

There is a comprehensive admission package on all services and levels of care provided. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six-monthly. Resident files included the general practitioner, specialist and allied health notes. Residents and families commented positively on the care received at West Harbour Gardens Residential Care.

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

A diversional therapist oversees the activity programme for the rest home and hospital residents including the younger people. An activity coordinator is employed to assist with the delivery of the programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group including the needs of younger people.

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

Safe and appropriate environment

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

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

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint steering group meetings at an organisational level. Interviews with the staff confirm

their understanding of restraints and enablers. On the day of audit, the service had four restraints (two bedrails and two lap belts) and no enablers.

Infection prevention and control

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

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 1 | 48 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 1 | 99 | 0 | 1 | 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) |
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| 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](#).

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

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

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

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| <p>respected, and upheld.</p> | | <p>documented on the organisation's electronic system (People Point). These are also monitored by head office.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility. Eight complaints received in 2016/2017 YTD were reviewed, with evidence of appropriate follow-up actions taken. There were no outstanding complaints. All complaints reviewed evidenced resolution to the complainants' satisfaction.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p> | <p>FA</p> | <p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The facility manager, the clinical coordinator and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All seven residents (four rest home level, two hospital level and one YPD) and five relatives (two rest home, three hospital) interviewed, report that the residents' rights are being upheld by the service. Staff interviewed were familiar with the Code of Rights Standard Operating Procedure (SOP).</p> <p>The prospective buyer owns an aged care facility in Auckland and has a good understanding of consumer rights.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend other churches if they wish. Residents interviewed reported that they can choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education around this has occurred.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> | <p>FA</p> | <p>The service has a Māori health plan and an individual's values and</p> |

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

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| | | <p>stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits. Physiotherapy services are provided on site, four hours per week with the support of a physiotherapy assistant three hours a day. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>The 2017 education sessions are being delivered as planned. Education sessions include opportunistic education identified by clinical coordinator and facility manager that require extra training.</p> <p>TerraNova has established benchmarking across its sites. There is a strong commitment to quality improvement at West Harbour Gardens and across the organisation. Improvement initiatives and quality goals are identified involving staff and are regularly reviewed. Steering groups for restraint, infection control and H&S are being implemented at an organisational level.</p> <p>Risk management reports are completed for residents at risk and service delivery risks such as (but not limited to) incidents/accidents, residents with pain, unexplained weight loss, identified depression. Action plans are implemented to minimise the risk and processes reviewed and evaluated. The risk management report is provided to head office and discussed, and shared through manager teleconferences.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fourteen accident/incident forms reviewed on (people point) reflected</p> |

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| | | <p>documented evidence of families being informed following an adverse event unless the (cognitively aware) resident chooses to notify family themselves. This information was documented on the accident/incident forms. Progress notes also identify family/whānau being kept informed.</p> <p>An interpreter service is available and accessible if required through the local district health board. Families and staff are utilised in the first instance.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>West Harbour Gardens residential care is part of the TerraNova homes. The service currently provides care for up to 74 residents. The service is certified to provide hospital (medical, geriatric) rest home and residential – physical/intellectual disability level care. On the day of the audit, there were 55 residents (49 residents and 6 boarders). There were 34 hospital residents (26 under the ARCC agreement, five YPD residents, one respite care, one long-term chronic conditions contract, and one resident under ACC). There were 15 rest home residents (including one respite and one long-term chronic). All resident rooms are dual-purpose; however, one wing is predominately hospital residents. Additionally, there were six boarders in rooms located in one corridor of one wing.</p> <p>The organisation has a vision, mission statement and objectives. There is an organisational business plan that links to the site-specific quality goals and objectives. Annual goals for the facility have been determined, which link to the overarching organisational plan. Quality goals for 2017 include; (i) The reduction of restraints by 50% based on 2016 figures. (ii) Reduce the rate of infections by 50% based on 2016 data. (iii) 90% of newly employed staff will have completed L2 certificate in Health & Wellbeing within 90 days of start date by end of December 2017. (iv) Increase staff attendance at training by 50%. Progress to meeting goals are regularly reviewed through meeting minutes.</p> <p>The managers across Terra Nova hold a teleconference weekly as a group with the CEO. One of the key focuses of the organisation is transparency and learning. Weekly teleconferences between managers and clinical managers, provides that opportunity. A monthly manager's report is completed at West Harbour; review/outcome is completed as</p> |

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| | | <p>part of that report and monitored by head office.</p> <p>The facility manager (RN) has been in the role for two years and has many years' experience in aged care management. The FM has also been managing Jervois home for the last 7 months and divides her time between the two sites. Interviews with the management team identified how communication is maintained. The clinical coordinator (RN) has been in the role for one year and has worked in aged care for the last four years. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The facility manager and clinical coordinator have maintained over eight hours annually of professional development activities related to managing an aged care service.</p> <p>The prospective provider owns a 40-bed hospital in Auckland. At the provisional audit, the auditor established that the prospective provider intends to continue with the quality processes as set out in the previous provider's quality plan. The current facility manager and the Terra Nova clinical quality and risk advisor will provide orientation and induction to processes and the clinical coordinator will stay on in charge of the clinical services. The prospective provider (chief executive officer) is a qualified chartered accountant and will oversee financial matters. Reporting processes will stay in place but reports will be to the new directors. The prospective providers' transition plan is to keep all operational processes the same with only the directors changing. The current owners have entered into contractual arrangements where they will provide Vendor Support for 20 working days following completion of the sale and provide core system services for up to 6 months from completion (at the election of the Purchaser) to allow ordered transition of these services..</p> <p>The prospective purchaser advises that there are no plans to make any changes to the facility. Proactive and reactive maintenance will be maintained as per current plan.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is</p> | <p>FA</p> | <p>A clinical coordinator/registered nurse (RN) who is employed full time, supports the facility manager, and steps in when the facility manager is absent. The service operational plans, policies and procedures promote</p> |

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| <p>managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | | <p>a safe and therapeutic focus for residents affected by the aging process and promotes quality of life. The prospective provider will assist the clinical coordinator in the absence of the facility manager.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems.</p> <p>TerraNova's policies, procedures and relevant forms are available both in hard copy and online under "Share Point" (intranet). Review of clinical policy, procedure etc. is coordinated by the Clinical Quality and Risk Advisor (CQRA) in conjunction with the facility managers and clinical coordinators. Approval of the amended/new document involves the executive management team before uploading and release of the document.</p> <p>Updated documents are released/supplied to the facility. A memo is sent to the managers along with printed copies of relevant documents for filing in their master hard copy folders. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place.</p> <p>TerraNova has robust quality and risk management systems implemented across its facilities. Across TerraNova, benchmarking is well established. The online 'ZAP reporting' system pulls data/clinical indicators from People Point (electronic system). This gives a more thorough analysis and is monitored by the TerraNova Clinical Quality & Risk advisor who supports the managers at West Harbour to further analyse the data and introduce corrective actions where needed.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure injuries, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results</p> |

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| | | <p>are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>A residents' meeting occurs monthly and an annual resident survey is completed. The recent 2017 survey identified that there was a slight decrease in satisfaction from the previous year in all areas surveyed. Quality projects were implemented as a result of the survey.</p> <p>Interviews with staff and review of meeting minutes/quality corrective action forms/opportunist education sessions, demonstrate a culture of quality improvements.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. H&S is an agenda item of the staff meeting. Hazard identification forms and a hazard register are in place. Health and Safety management has been improved with organisational three monthly H&S meetings, the appointment of a H&S Officer and Rep and a focus on reducing hazards and promoting safe work habits amongst employees.</p> <p>Three steering groups at an organisational level have been implemented including a restraint, H&S and infection control group. A representative from West Harbour attends each of the organisational steering groups.</p> <p>A robust risk management system is in place with the clinical coordinator completing a monthly risk management report with corrective actions. Incident management is well managed, with all incidents being reported on 'people point' and reviewed by the clinical coordinator and facility manager (FM) daily. Incidents are also able to be reviewed in detail by the CEO and CQ&R advisor on 'people point'.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Fourteen accident/incident forms were reviewed (from June 2017). Accident/incident forms and electronic records of incidents (on People Point) identify follow-up by a RN. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incidents are benchmarked and analysed for trends. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. There is also a number of ongoing quality improvements identified through meeting</p> |

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| | | <p>minutes and as a result of analysis of quality data collected. West Harbour is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. Progress report follow up includes comprehensive review and evaluation from both the clinical manager and facility manager. The service is proactive around reporting to families around corrective actions taken as a result of follow up of the I&A.</p> <p>The facility manager was aware of the requirement to notify relevant authorities in relation to essential notifications. The facility manager was able to provide copies of Section 31 notifications to the Ministry of Health with regards to pressure injuries.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (FM, CM, RN, two caregivers, one activity coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are buddied-up for a period of time and during this period they do not carry a clinical load. The orientation booklet aligns with NZQA foundations level two and they have 90 days to complete. On completion of this orientation, the staff member has attained their first national certificate. From this, they are then able to continue with Core Competencies Level-3 unit standards.</p> <p>The 2017 education planner is implemented. Education sessions are being delivered as planned to include opportunistic education around areas of development identified by CC and FM that require extra training, (eg, PEG feeding, care of PEG site). Specific education has been provided in relation to the current needs of their young people (YPD). Education and training for clinical staff is linked to external</p> |

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| | | <p>education provided by the district health board. The service has well exceeded over 8 hours of training provided annually.</p> <p>A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Competencies include (but not limited to) cultural, glucose monitoring & insulin, fire safety, medication, manual handling, controlled drug checking, restraint SC administration, infection control, wound care and compression bandaging.</p> <p>Three of seven registered nurses are currently ilnterRAI trained.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>The staffing levels meet contractual requirements. The facility manager is responsible for the management of West Harbour Gardens and another Terra Nova site - Jervois Residential Care. The prospective purchaser is planning to purchase both West Harbour and Jervois Residential Care. Advised that the current facility manager will continue with change of owner spending three days onsite a week at West Harbour Gardens, and two days at Jervois Residential Care. The clinical coordinator works Monday – Friday and shares on call out of hours with the facility manager and the clinical coordinator at Jervois Residential Care.</p> <p>On the day of audit there were 49 residents and six boarders.</p> <p>There are two registered nurses on duty on the morning and afternoon shifts and one registered nurse is on duty overnight.</p> <p>There are six caregivers (working various hours) each morning. In the afternoon, there are four caregivers on duty. At night, there are three caregivers on duty (one in each wing).</p> <p>The prospective provider has had time to complete a thorough investigation into current staffing needs. The prospective provider will be taking over the current policies of the service and continue to use the policies for guiding service provision, this includes the current skill mix policy. Plans are in place to keep the mix and quality of staff the same as that currently in place.</p> |

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| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. All staff have access to areas relevant to them on the People Point electronic care record system. Electronic records are protected from unauthorised access. Hard copy records are held securely.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. Electronic records clearly identify staff member and time.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p> | <p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The service screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARRC contract. Registered nurses assess all residents on entry to service. Initial information gained is paper based and is included in the resident computer based system. RNs interviewed could describe the entry and admission process. The GP is notified of a new admission.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.</p> |

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| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The service utilises two-weekly robotic rolls. All medications were securely and appropriately stored. Registered nurses administer medications and had completed annual medication competencies and education. Caregivers who act as second checker had a medication competency. There was one resident self-medicating on the day of audit. Self-medication competencies for that resident had been completed. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication folders include a list of specimen signatures and competencies.</p> <p>Medication profiles reviewed were legible, up-to-date and reviewed at least three-monthly by the GP. Medication charts have photo IDs and allergies stated. All medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges. Medication administration charts were signed as medication was administered. Medication trollies are stored in each wing (trollies are restocked daily).</p> <p>Fourteen medication charts were reviewed (eight hospital and six rest home). Medication rounds were observed and the medication process delivered by the RNs was noted to be safe and correct.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>A dedicated kitchen manager who is employed Monday to Friday oversees food management. A second cook and three kitchen hands provide cover across seven days. The food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and there is a national menu in place that has been audited and approved by an external dietitian (last reviewed March 2017). The seasonal menu rotates over a four-week cycle. There are policies in place to guide staff. Food is procured from commercial suppliers. Food is cooked on-site in a large well-equipped kitchen. There is sufficient storage available. Stock rotation is practised. Hot food temperatures</p> |

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| | | <p>are monitored daily. Fridges and freezers have temperatures monitored twice daily.</p> <p>Resident likes and dislikes are known, recorded in the kitchen and alternatives are offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes and is reviewed six-monthly, as part of the care plan review. Special diets (ie, soft and pureed diets) are noted on the kitchen noticeboard, which can be viewed only by kitchen staff. Meals are served straight from the kitchen to the residents in the dining room and can be delivered to rooms as required. Specialist utensils and plates are available for residents.</p> <p>The resident annual satisfaction survey monitors food satisfaction. The kitchen is included in the internal audit programme. Staff have been trained in safe food handling and chemical safety.</p> <p>Residents and relatives interviewed commented positively on the meals provided.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>There is policy in place regarding the process for declining entry. Residents are declined entry when there are no beds available or, if the person has health needs that are not able to be provided by the facility. If a potential admission was declined entry, the resident and where appropriate their family/whānau of choice, is informed of the reason for the decline and referred back to the referring agency.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Assessments were completed when there was a change to a resident's health condition. The InterRAI assessment tool is implemented (link 1.3.3.3). Care plans sampled were developed on the basis of these assessments.</p> |
| <p>Standard 1.3.5: Planning</p> | FA | <p>All resident care plans sampled were resident-centred and support</p> |

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| <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | | <p>needs were documented in detail. Care plans demonstrated service integration and documented input from allied health and specialist care professionals. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. One YPD resident had clear instructions for management of specific needs including (but not limited to) PEG feeding. The contracted physiotherapist has completed transfer plans.</p> <p>Short-term care plans were in use for changes in health status and signed off as resolved or transferred to the long-term care plan.</p> <p>The respite resident file reviewed had a 24 hr assessment and 'high needs resident approval form' which included assessed needs. The assessed needs were reflected under interventions in a LTCP format and covered mobility (use of aids and falls prevention measures), sleep and nutrition which included swallowing difficulties.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>All care plans reviewed included documentation that meets the needs of the residents. Where resident needs had changed, care plans had been updated. Interview with the GP evidenced that care provided is of a high standard and GP is kept informed. Family members interviewed stated care and support is good and that they are involved in the care planning.</p> <p>Caregivers and RNs interviewed state there is adequate equipment provided (including continence and wound care supplies). Wound assessment, wound management and evaluation forms are in place. Wound management and monitoring occurred as planned. All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Care plans document allied health input. There was one wound register in the facility. A sample of wounds reviewed in detail included a link to STCPs and LTCPs. There is DHB wound care nurse specialist input where needed. Physiotherapy and dietitian input is provided for residents.</p> <p>Monitoring charts were well utilised and examples sighted included (but not limited to) weight and vital signs, blood glucose, pain, food and fluid,</p> |

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| | | repositioning charts, behaviour and restraint monitoring. |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>West Harbour Gardens employs a Diversional Therapist (DT) part time (three days per week). An activities assistant is employed full time. The activities core programme is currently delivered Monday to Saturday. The programme provides activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Time is spent with residents and relatives to further explore their individual life goals and to aid development of these new and meaningful activities. Music and pet therapy is offered.</p> <p>All residents may choose to attend any of the activities offered. One young person interviewed stated they enjoy the activities offered and attend activities of their choice. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme.</p> <p>There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events.</p> <p>Resident meetings were held monthly and open to families to attend.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Care plans reviewed had been evaluated by registered nurses' six-monthly, or when changes to care occurred. Written evaluations describe the resident's progress against the residents (as appropriate) identified goals or desired outcomes. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, allied health, wound care nurse, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend.</p> |

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| | | There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical coordinator and two registered nurses identified that the service has access to a wide range of support either through the GP, DHB specialists and or contracted allied services. YPD residents are assisted to access community groups and health services as needed. |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | There is an effective system of waste management in place. Used linen is appropriately managed and all laundry is managed offsite. Chemicals are supplied by an external contractor and stored securely throughout the facility when not in use. Appropriate policies are available along with material safety datasheets. Education on hazardous substances occurs. There is appropriate signage throughout regarding chemical storage and hazards. There is personal protective equipment available for use by staff and this was in use on the day of audit. Staff interviewed (housekeeping staff, caregivers, RNs) were knowledgeable about chemical safety. |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | The building holds a current warrant of fitness, which expires 16 November 2017. The facility employs a part-time maintenance officer. The maintenance officer is a member of West Harbour Gardens Health & Safety committee. There are proactive and reactive maintenance management plans in place. Hot water temperatures are monitored and recorded monthly. Where temperature has exceeded 45 degrees, the service has implemented corrective actions. Electrical testing and tagging was last completed on 18 August 2016. Medical equipment |

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| | | <p>requiring servicing and calibration was last completed April 2017. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers. They hold a current driver's license and a current first aid certificate.</p> <p>Two rooms were being refurbished at the time of audit and were unoccupied.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>All resident rooms have a vanity. Each wing has four communal toilets. Showers are in link corridors between each wing. There are eight communal showers altogether. Resident rooms have hand-washing facilities with soap dispensers and paper towels. Communal bathroom and toilet facilities have a system that indicates if it is engaged or vacant. Privacy is further maintained by additional curtains behind doors in some areas. Equipment includes a shower trolley, commodes and shower chairs.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>Residents' rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur on an ambulance stretcher and equipment can be transferred between rooms. Mobility aids can be managed in communal bathrooms.</p> <p>Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.</p> <p>There was room to store mobility aids such as walking frames, in the bedroom, safely during the day and night if required.</p> |

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| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>The service has a large central atrium where most activities and dining takes place. Rata wing and Ngaio wing each have two smaller lounges. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed agreed that the service is spacious and residents may stay in their own wings or join in any of the communal lounges.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>FA</p> | <p>All laundry is completed off site. There is a storage area for dirty laundry waiting to be picked up and a clean area for clean laundry deliveries. All clean personal laundry is prepacked into individual resident named bags by the laundry service therefore there is no sorting of clothing to be completed by staff. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety datasheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training. There is a sluice room adjacent to each communal shower block.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>There is an approved evacuation scheme in place, dated 28 August 2015. There is a comprehensive civil defence and emergency procedures manual in place. The civil defence kit is readily accessible. A store of portable emergency water is kept. An emergency food supply, sufficient for three days, is kept in the kitchen. All key staff hold a current first aid certificate. The facility is secured during the hours of darkness. Staff are security conscious. An external security firm monitors the facility overnight. Appropriate training, information, and equipment for responding to emergencies is provided. The latest fire evacuation was held January 2017. Fire evacuation drills are held at least six-monthly to ensure all staff are well trained. The call bell system is available in all areas and there are indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells or where appropriate sensor mats were in use. Residents interviewed stated that their bells are answered promptly.</p> |

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| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | Resident's rooms, including the two new care rooms, are provided with adequate natural light, safe ventilation, and in an environment, that is maintained at a safe and comfortable temperature. |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator is the clinical manager and she is responsible for infection control across the facility. The organisational IC steering group is responsible for the development of the infection control programme and its review. The facility review is also completed through the IC programme review internal audit. The infection control programme is well established at West Harbour. The infection control committee is incorporated as part of the staff meeting. There have been no outbreaks since the previous audit. |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | There are adequate resources to implement the infection control programme at West Harbour. The infection control (IC) coordinator has maintained best practice by keeping up-to-date with infection control updates. The IC coordinator has also completed IC training online through MOH. The infection control team is representative of the facility and is incorporated as part of the staff meeting. External resources and support are available through the HCPNZ, simple solutions and the TerraNova IC steering committee that meets bi-monthly. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant</p> | FA | The infection control manual outlines a range of policies, standards (SOP) and guidelines, defines roles, responsibilities and oversight, surveillance, training and education of staff and scope of the programme. The policies and procedures are currently in the process of |

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| <p>legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | | <p>being updated.</p> |
| <p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held and has been completed in 2017.</p> <p>The infection control coordinator has received education both in-house and by an external provider to enhance her skills and knowledge. The infection control coordinator has access to the TerraNova IC steering group for resources, guidelines best practice and group benchmarking. Infection control is also a component of the wound care competencies completed by RNs. There is also an IC competency completed by all staff.</p> <p>A number of education talks have been provided at handover including (but not limited to) preventing UTIs, eye care and hand hygiene.</p> |
| <p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>CI</p> | <p>Infection surveillance is an integral part of the infection control programme and is described in the TerraNova infection control manual.</p> <p>An individual resident infection form is completed (IC wizard on People Point). Monthly infection data is collected for all infections based on signs and symptoms of infection. These are reported into Simple Solutions benchmarking programme. An infection analysis summary is auto-populated. The IC coordinator has utilised these summaries to identify trends and reduce infections. Graphs, corrective actions and outcomes are shared with staff.</p> |
| <p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint/enabler management procedures. There are clear guidelines in the policy to determine what a restraint is and what</p> |

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| | | <p>an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint steering meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had four restraints (two bedrails and two lap belts) and no residents using an enabler.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p> | FA | <p>Only staff that have completed a competency assessment are permitted to apply restraints. The RN, restraint coordinator, GP and manager sign off restraint use. Staff complete competency assessments annually. These are completed with the restraint coordinator. The restraint procedure includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is a registered nurse and has a signed job description, and understands the role and her accountabilities.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>The restraint coordinator, RN, manager and GP, in partnership with the resident and their family/whānau, undertake assessments. A registered nurse is the restraint coordinator.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. The files of two residents on the restraint register were reviewed. There was a restraint assessment completed (restraint/enabler & de-escalation evaluation form) in both files. The care plan was up-to-date and provides the basis of factual information in assessing the risks of safety and the need for restraint. Interventions were documented under the 'behaviour section' of the care plan. Ongoing consultation with the resident and family/whānau is also identified. Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and need for restraint.</p> |

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| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | <p>FA</p> | <p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.</p> <p>The assessments reviewed referred to specific interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed (of two hospital residents with restraint), identified observations and monitoring. Restraint use is reviewed and documented on the three-monthly evaluation form. Restraint is also reviewed at the three-monthly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input. An up-to-date restraint register was in place. Monitoring of restraint is documented on the 'people point' computer programme and links into progress reporting.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three-monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their care plan review. The family is included as part of the MDR review. Evaluation timeframes are determined by risk levels. Monitoring of restraint is documented on the 'people point' computer programme and links into progress reporting.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>Individual approved restraint is reviewed at least three-monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. There is an active organisational restraint steering group. Review of this use across the group and progress towards achieving the organisational quality goal of reducing restraint use by 65% is discussed at that meeting and information is disseminated throughout the organisation. The organisation and facility are very proactive in minimising restraint usage. West Harbour is focused on</p> |

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| | | minimising restraint. |
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Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.3.3</p> <p>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.</p> | PA Low | The registered nurse completes an initial assessment within twenty-four hours of admission and documents the initial care plan. Four of the four ARCC resident files reviewed identified that InterRAI assessments had been completed outside the required timeframes. Delays had been identified by the service prior to audit and a new schedule had been implemented, and evidence of progress made towards addressing the problem. | <p>(i) One InterRAI assessment was not completed within twenty-one days of admission. The sample was increased and a further four new admissions in the last 6 months did not have an interRAI completed within 21 days.</p> <p>(ii) Four InterRAI re-assessments were completed outside the six-monthly timeframe.</p> | <p>Ensure that InterRAI assessments are completed within contractual timeframes.</p> <p>90 days</p> |

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.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| <p>Criterion 3.5.7</p> <p>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.</p> | CI | <p>Internal infection control audits assist the service in evaluating infection control needs. There is close liaison with the general practitioners and the laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.</p> <p>The IC programme is linked with the quality management programme. Quality improvement initiatives are undertaken and recorded as part of continuous improvement. Documentation covers a summary, investigation, action taken and evaluation.</p> | <p>The service continues to exceed the required standard around infection control surveillance. West Harbour has undertaken a number of initiatives to reduce infection numbers as a result of infection surveillance data. IC statistics are discussed at all meetings and corrective actions are implemented when infections increase. An example includes the service benchmarking identified an increase in the number of infections reported. The service introduced strategies including (but not limited to) increasing fluid rounds, handwashing competencies, education for staff around genital hygiene techniques and prevention of skin tears. Ongoing review of the monthly risk management report to head office demonstrates ongoing review of strategies</p> |

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| | | | <p>and re-evaluation.</p> <p>The quality goal to reduce infections by 50% based on 2016 data is currently being achieved. Total infections rate for rest home residents in the first quarter of 2016 was 12.8 per 1000 bed nights that has decreased to 2.1 in the first quarter of 2017 evidencing a reduction of 83%.</p> <p>In the hospital, the total infections for the first quarter in 2016 was 11.1 per 1000 bed nights that has reduced to 2.1 in the same quarter in 2017, a reduction of 81%.</p> |
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End of the report.