

Bima Health Limited - Sunhaven Rest Home & Private Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bima Health Limited
Premises audited:	Sunhaven Rest Home & Private Hospital
Services audited:	Hospital services - Psychogeriatric services; Dementia care; Residential disability services - Psychiatric
Dates of audit:	Start date: 4 August 2020 End date: 5 August 2020
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:	40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Sunhaven Rest Home & Private Hospital (referred to as Sunhaven) can provide care for up to 40 residents/consumers. There is a dementia unit, psychogeriatric unit and residential disability – psychiatric unit. The residential disability – psychiatric unit has been operating since October 2018 and was added to the service under discussions with the district health board (DHB). The dementia and psychogeriatric areas are secure. The mental health consumers are able to come and go.

This certification audit was conducted against the Health and Disability Service Standards and the organisation's contract with the DHB. The audit process included the review of policies and procedures; a sample of resident/consumers and staff files; observations, and interviews with family/whanau, management, staff, the owner/proprietor and visiting allied health professionals.

The organisation has achieved full compliance to this standard and their contract with the DHB. Two areas of continuous improvement were identified relating to the quality improvement programme and staff education.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service provides care that reflects the Code of Health and Disability Services Consumer Rights (the Code). Information about the Code is promoted and shared with consumers, family/whanau members and staff. Residents/consumers are encouraged to maintain cultural customs and connections with their community. Care and support are delivered in line with good practice. Communication needs are met. Consumers and family/whanau advised that the service treats them with dignity and respect. The complaints process complies with consumer rights legislation.

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.
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The organisation is governed by the owner/proprietor. The mission statement, vision, goals and philosophy are reviewed, documented and displayed. Business objectives and responsibilities are defined. Organisational performance is monitored. Day to day management is the responsibility of the facility manager, owner and clinical manager.

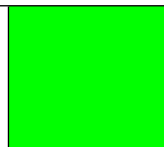
There is a documented and implemented quality and risk management system. The required policies and procedures are documented. Quality outcomes data is collected and analysed to improve service delivery. Quality improvements are developed, implemented and monitored. An internal audit schedule is implemented. Adverse events are managed in line with best practice and reported as required.

The human resource management system has been maintained and is consistent with accepted practice. There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery for all residents.

Consumer information is fully documented and maintained securely.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Access to Sunhaven is efficiently managed with relevant information provided to the potential consumers.

The process for assessment, planning, evaluation, and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented and these are based on a comprehensive range of information and accommodate any new problems that might arise.

Files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents and mental health consumers are referred or transferred to other health services as required. All consumers requiring residential disability care are assessed for risk and where required a risk and/or an acute management plan is developed and monitored. These are completed by competent and suitably qualified staff members.

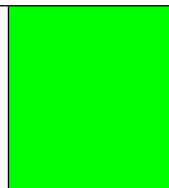
The planned activity programme provides residents in the secure dementia area with a variety of individual and group activities and maintains their links with the community. A weekly activity schedule is developed for each consumer in the mental health unit with activities that are appropriate to the assessed individual needs and abilities. Activities are strength based and recovery focussed.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents and consumers with special needs catered for. Food is safely managed, and snacks and drinks are available on a 24-hourly basis. There is a current food control plan.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The building is fit for purpose. There is a current building warrant of fitness and approved evacuation plan. Ongoing maintenance and compliance monitoring ensure that the physical environment meets the needs of the residents/consumers and health and safety requirements. Electrical and medical equipment, furniture and fittings are maintained in safe working order. Emergency management plans and equipment are in place.

Residents/consumers have private bedrooms. There are sufficient communal areas within the facility, and the garden, for residents/consumers to enjoy. Outdoor areas are maintained to ensure safety and security.

There are documented cleaning and laundry procedures. Personal protective equipment is readily available. Appropriate training, information, and equipment for responding to emergencies are provided. Cleaning and laundry services are monitored.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

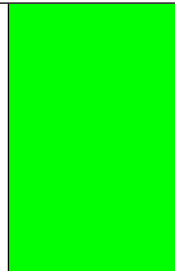


Standards applicable to this service fully attained.

There are clear and detailed documented guidelines on the use of restraints and management of challenging behaviours. There was one resident using restraint on the days of the audit. Staff interviewed demonstrated a good understanding of restraint use and receive ongoing education in restraint, challenging behaviours, and de-escalation techniques through in-service training. The staff have completed appropriate training to provide safe care.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by a trained infection control officer, aims to prevent, and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed through the local district health board when needed. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. The organisation implemented and maintained Ministry of Health guidelines during the COVID-19 pandemic as required.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>All staff interviewed were aware of the Code of Health and Disability Services Consumers' Rights (the Code) and how it is implemented into everyday practice. Staff were able to provide examples of how the Code is applied in the dementia/psychogeriatric areas and with the mental health consumers. Staff receive training regarding the Code both at orientation and again regularly during in service education. Evidence of orientation and education was sighted in all staff records sampled.</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>The informed consent policy and procedure meets requirements and includes the use of advance directives. The required consents were sighted in all resident/consumer records sampled. Consents for residents in the dementia and psychogeriatric areas were signed by the appropriate person. For example, next of kin or the enduring power of attorney. Protection of Personal and Property Rights (PPPR's) were in place where required.</p> <p>Resuscitation treatment forms were sighted in resident records sampled. These were signed by the residents' general practitioner, with input from the resident/consumer if able, and significant other. A district health board medical care guidance form is also completed for any resident who does not have an advance directive due to being assessed as incompetent.</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>	<p>FA</p>	<p>The right to independent advocacy is included in service information. In interview, the facility manager reported that independent advocacy can be accessed if required. There were no concerns voiced by family/whanau and consumers interviewed regarding their right to access independent advocacy services, or the persons of their choice.</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>	<p>FA</p>	<p>The names of significant others and family/whanau are gathered during the assessment and care planning process. Level of involvement with family/whanau is discussed. A record of all family/whanau contact is maintained. Ongoing discussions are in place with community mental health services regarding the requirements for contacting mental health consumers family/whanau members subject to their consent. All residents/consumers are able to have the visitors of choice. A visitors' book is maintained for the secure areas.</p> <p>Residents/consumers have a wide variety of access to community services. This includes input from allied health providers such as psychiatrists and key workers for the mental health consumers. Family/whanau were observed picking up their family member for community outings and support is provided for residents/consumers to access specialist appointments as required.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints process meets the requirements of Right 10 of the Code. Staff, family/whanau and mental health consumers interviewed confirmed their knowledge of the complaints process. Complaint forms are easily accessible at the entrance of the facility. There have been no complaints to external authorities. There were no complaints in 2019 and one thus far in 2020. This complaint was regarding an alleged breach in lock down processes, was fully investigated and found to be unsubstantiated. Records of the complaint and investigation were fully documented, responded to and closed in a timely manner. A summary of the complaint was included in the complaints register.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>All residents/consumers and family/whanau receive information regarding their rights. This information is provided on entry to the service in the information booklet. The Code is displayed throughout the facility and is available in English and Te Reo. Family/whanau members and mental health consumers interviewed confirmed that rights are respected and sufficient information was made available. All those interviewed stated that staff and management were approachable and easily accessible should any concerns or clarification be required. Mental health key workers are also available to the mental health consumers and work as the interface between the psychiatrist and the service. Staff were all clear regarding the residents enduring power of attorney (EPOA) and when</p>

		they are required to contact them. Consumer rights is included in the satisfaction survey process. Records of surveys sampled confirmed satisfaction with services, including respect for their rights.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are sufficient areas throughout the facility to support privacy. All residents have their own room, clinic rooms are available as are additional areas which can be used for private discussions. Respect for privacy was observed during the audit. Personal belongings are documented on admission and maintained securely in each of the residents/consumer rooms. Family/consumer interviews and satisfaction surveys sampled confirmed that privacy, dignity and respect is maintained.</p> <p>There is a documented policy and procedure on abuse and neglect. Training on abuse and neglect is provided to staff annually. The procedure is cross referenced to the complaints and adverse event reporting system. There have been no documented reports of abuse or neglect. A representative from Aged Concern is a regular visitor to the service.</p> <p>Residents/consumers are supported to maintain as much independence as possible. Goals for independence are documented. Supporting and promoting independence was specifically evident, and observed, with the mental health consumers. Individual values, beliefs and cultural needs are identified during the assessment process.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <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>	FA	<p>The Maori policy and procedure and the Maori Values procedure make reference to the Treaty of Waitangi, Maori models of health, barriers to access and national health strategies. Individual Maori health plans are documented for residents/consumers who identify as Maori. These include the four cornerstones of health and were sighted in relevant resident/consumer records sampled. In interview, the facility manager reported that the organisation has access to a community Maori support person, who is available to provide support to the residents/consumers as required.</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>	FA	<p>There is a cultural safety policy and procedure. Residents, family/whanau and consumers are consulted regarding their individual values and beliefs. Cultural needs are included in the assessment and care planning process and was documented in files sampled. Consumers and family/whanau members confirmed that cultural values and beliefs were respected. Respects for individual cultural values and beliefs is also included in the annual surveys, which confirmed satisfaction. Sunhaven supports cultural and religious celebrations throughout the year.</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>The discrimination policy and procedure is cross referenced to the Code and Human Rights Legislation and provides guidelines regarding the identification and investigation/complaints process. Professional boundaries and misconduct is included in the staff employment agreement. The agreement also includes house rules regarding discrimination and abuse. There was no evidence of discrimination observed during the audit, and no related adverse events documented.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Sunhaven encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist, dietitian, mental health services, and education of staff. Staff attend internal monthly education sessions; good attendance was noted on the reviewed education attendance records.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included records of monthly staff meetings where different topics concerning residents and consumers are discussed along with other organisation wide topics. For example health and safety, infection control, incidents, complaints, compliments, restraint and audit results.</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>A communication strategy is documented in the business plan. The director/proprietor and facility manager maintain an open-door policy. This was confirmed in interview with family/whanau and consumers. Open disclosure was evident in adverse event records sampled. A record of phone contact with relatives is maintained.</p> <p>Sunhaven provides all family/whanau members with newsletters and regular updates. The frequency of these updates was increased during the COVID-19 pandemic to continually reassure family/whanau members regarding the residents/consumers wellbeing. Records of emails and interviews with family/whanau confirmed their deep appreciation for the addition communication from the rest home during the lock down period.</p> <p>In interview, the facility manager reported that interpreter services are available in the community if required. There a diverse range of staff who speak a variety of languages and dialects.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>The director/proprietor is the sole owner and purchased the rest home/hospital in 2009. Previous to 2009, the director has owned two other aged care services and has been in the industry for over 30</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>years. The purpose, values, mission and goals are documented in the business plan. The business plan is documented annually and includes an executive summary, company description, issues impacting on operations, a marketing strategy, maintenance goals and improvements, financial management and measurable business goals. The business plan has been updated to include mental health services. An organisational chart is documented.</p> <p>Business objectives include the management of vacancies, staff training, policy and procedure reviews, providing quality care, monitoring of the mental health service, building maintenance and improvements. Achievement towards the business objectives and goals are monitored by the director and facility manager who are both onsite weekdays and available after hours.</p> <p>The facility manager has been at Sunhaven for 14 years and is responsible for day to day business and general management of the home. The facility manager has completed business management papers and has a background in commerce and health administration. The facility manager has attended the required number of hours training annually. Training over the last year has included topics such as complaints investigation and reporting, employment law and leadership in aged care training provided by the district health board. The facility manager is also a career force assessor and is supported by the acting clinical manager.</p> <p>There are 40 beds in the whole service. The service has agreements with the DHB for the provision of aged residential care – dementia and psychogeriatric care (both secure units) and residential mental health under a long-term support contract. The residential disability – psychiatric service provides eight non-secure beds. There were seven consumers in the residential disability – psychiatric unit during the audit. There are 20 psychogeriatric beds and 12 dementia beds. These beds were fully occupied on the days of the audit. The rest home also has a contract for respite and day care through the district health board. There was one mental health respite consumer at the service during the audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The management team consists of the director/proprietor, the facility manager and the clinical manager. The director is available to perform the management role during a temporary absence of the facility manager. There are also suitably qualified registered nurses available within the staff to step into the clinical manager's role during an absence.</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>There is a documented quality and risk management system. The required policies and procedures are available and accessible. Policies and procedures are reviewed every two years or more frequently as required and have been amended to include the residential disability – psychiatric service. Policies reflect current good practice, legislation and compliance requirements. There is a system for updating, reviewing, approving, controlling and removing obsolete documents from circulation.</p> <p>Quality related data and outcomes are collated, analysed and shared with staff at regular staff and quality meetings. There is a process to measure achievement against the quality improvement plan. Quality indicators are documented and measured through the audit/satisfaction programme. Quality meetings occur every three months and are attended by representatives throughout the organisation. Meeting minutes sampled (June 2020 and February 2020) confirmed that quality related data is discussed, including quality improvements and business plans, complaints, compliments, adverse events, quality improvements, staffing, service delivery, restraints, hazards, risks, internal audits and maintenance. The quantity and quality of service improvements has resulted in a continuous improvement rating (refer criteria 1.2.3.6).</p> <p>The internal audit schedule is developed annually. Audits cover the scope of the system and include goals, methods to measure, evidence that is required to evaluate the outcome and level of compliance. The schedule has been fully implemented. Corrective actions are documented and implemented where a variance is identified. Trends are reviewed to improve service delivery. Family/whanau are provided with annual satisfaction surveys which confirmed overall satisfaction with the services provided. A compliments register is also maintained.</p> <p>A risk management plan is documented. Risks are analysed, monitored and discussed regularly between the facility manager and director. Issues impacting of business are included in the annual business plan.</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>The incident policy and procedure meets requirements and includes the identification of trends and quality improvements. The adverse event reporting system has been maintained. The facility manager is aware of essential notification reporting requirements. There has been no requirement to notify an external authority of any adverse event since the last audit.</p> <p>A sample of the adverse event records confirmed that incidents and accidents are being reported and followed up in an appropriate and timely manner. Records included evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner if required. There was evidence of open disclosure and family notifications on incident forms and resident records. Both family members</p>

		<p>and the general practitioner interviewed confirmed that incidents are reported in a timely manner. Incidents and accidents are collated and discussed at quality meetings. Monthly statistics on all documented adverse events are collated, analysed and reported at meetings. Falls are the most commonly documented incident. This includes a process for the management of both witnessed and unwitnessed falls.</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>	FA	<p>The human resource management system is fully maintained and meets legislative requirements. Staff records sampled included an employment agreement, evidence of current qualification and practicing certificate and a position description. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education. Staff interviewed reported that the orientation programme is comprehensive, supportive and prepares them well for the tasks required.</p> <p>A training plan is documented and implemented annually with regular monthly training sessions provided. Performance appraisals are completed for all staff which ensures that any individual training needs are identified. The organisation continues to provide a training programme which exceeds the requirements of this standard and their agreement with the district health board.</p> <p>There are four registered nurses who have completed the required interRAI training. Medications are administered by registered nurses and healthcare assistants who have been assessed as competent. Three of the staff working on the residential disability – psychiatric unit have completed the mental health diploma and are receiving ongoing support/input from the district health board mental health team. All staff have completed the required dementia training. Kitchen staff, cleaners and the activities coordinators have all received the required relevant education.</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>	FA	<p>The process for determining staffing levels and skill mix is defined in policy and takes into account the layout of the facility and levels of care provided, including the mental health unit. Staff rosters are developed by the facility manager, with input from the clinical manager.</p> <p>The clinical manager is rostered on week days, and shares on call duties with the other RN's. There is a registered nurse in charge on each shift. The registered nurses hold current first aid certificates with all registered nurses having completed training through the DHB relevant to their role. All health care assistants and mental health support workers have cardio pulmonary resuscitation (CPR) training.</p> <p>Rosters sampled confirmed that there are sufficient numbers of staff in each area to meet the needs of the residents, with shift gaps covered in the event of a temporary absence. Additional staff are</p>

		available in the event a resident requires one on one support. Staff state that they can call for assistance after hours, with the manager and owner available at all times. There are additional designated staff for cleaning and laundry duties and a 'lounge' staff member in the high needs dementia area.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The consumer information policy and procedure include records management and the requirements regarding data entry. Resident/consumer information is accessible in hard copy. Resident/consumer files sampled were comprehensively documented including all the necessary demographic, clinical and health information. All information is maintained in a secure manner. Personal information, other than a name on the residents' bedroom door, was not publicly accessible. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Entries into resident/consumer records are made daily. All entries sighted were legible, included the time of entry and the writer's designation. The residents/consumer name was identifiable on each page.</p> <p>Records were integrated. Allied providers completed entries in the residents/consumers individual folder. These included entries made by the activities staff, general practitioner, key workers and visiting psychiatrist. Adverse event reports were also filed into the resident/consumer folder once they had been investigated, closed and added to the data base.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Admission into the service is managed by the facility manager (FM), acting clinical manger and the registered nurses (RNs). Residents and consumers enter the service when their required level of care has been assessed and confirmed by the local needs' assessment service (NASC). Information about the service is documented and clearly communicated to the consumers, their family/whanau/EPOA, local communities and referring agencies. Prospective residents/consumers and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and general practitioner (GP) for residents accessing respite care.</p> <p>The consumers, family members and/ the enduring power of attorney (EPOA) interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files sampled contained completed demographic data, assessments, and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements and are documented in the admission agreement.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The RNs and the acting clinical manager are responsible for managing the exit, discharge, or transfer in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses their facility owned transfer form to facilitate transfer of residents to acute care services. There was open communication between all services, the resident/consumer and the family/whānau. At the time of transition between services, appropriate information was provided for the ongoing management of the resident. Referrals were documented in the progress notes sampled. An example of a resident recently transferred to the local acute care facility showed adequate documentation was completed. Family/EPOA of the resident reported being kept well informed during the transfer of their relative.</p> <p>If the needs of a resident/consumer change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the consumer and whānau/family/EPOA. Examples of this occurring were discussed. There is a clause in the admission agreement related to when a resident's/consumer's placement can be terminated.</p>
<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>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the days of audit. The electronic system is accessed using individual passwords. The RNs were observed administering medication correctly. They demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage and had a current medication administration competency. The electronic prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for 'as required' (PRN) medicines. The three-monthly medication reviews were consistently recorded on the electronic medicine chart.</p> <p>The service uses pre-packaged medication packs which are checked by the RNs on delivery. The medication and associated documentation was stored safely, and medication reconciliation is conducted by RNs when resident is transferred back to service. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There was no food stored in the medicine fridge. There were no vaccines</p>

		<p>kept on site.</p> <p>There were no residents who were self-administering medications at the time of audit. There was one resident under the Mental Health Act who has covert medication administration. Appropriate processes and documentation were completed.</p> <p>The acting clinical manager reported that a comprehensive analysis of any medication errors is completed as required as guided by the medication management policy.</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>There is a four-week rotating roster which is reviewed by a registered dietician as required. In addition to the required biannual menu review, a dietician also completes regular reviews with the RN's to ensure individual nutritional needs are being met (refer continuous improvement rating in standard 1.2.3). In-service staff training on nutrition was last provided in June 2020 by a dietician</p> <p>The residents/consumers nutritional requirements are assessed by the registered nurse on entry. The nutritional assessment is comprehensive and identifies preferences and any special requirements. Resident/consumer weight is monitored and there was evidence that any concerns in weight were identified early and managed appropriately. Additional supplements were provided where required, and there has been success with residents/consumers who needed to lose weight to achieve optimum health benefits.</p> <p>Meal times were observed during the audit and confirmed that all residents/consumers received the support they needed. All meals are served with fluids. Additional foods and fluids are accessible throughout the day and night if required. The mental health consumers can independently prepare their own snacks and drinks.</p> <p>All aspects of food procurement, storage and preparation met requirements. Kitchen staff have the required food safety qualifications. Temperature checks of fridges, freezers and cooked meats are maintained. There is a current food control plan. The food control plan verification report and checklist was sighted.</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</p>	<p>FA</p>	<p>The acting clinical manager reported that if a referral is received but the prospective resident/consumer does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective consumer, resident or family are supported to find the appropriate care required. The consumer and where appropriate their family of choice/EPOA are informed of the reason for declining entry to services.</p>

organisation, where appropriate.		
<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>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, continence, as a means to identify any deficits and to inform care planning. The care plans sampled had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. InterRAI assessments for the consumers in the psychiatric unit are completed by the mental health key workers. Risk assessments were completed for the consumers. Consumers and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans sampled reflected the support needs of residents and consumers, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the reviewed care plans. Recovery and relapse prevention plans were completed for the mental health consumers.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Consumers and families reported participation in the development and ongoing evaluation of care plans.</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>	FA	<p>Documentation, observations, and interviews verified that care provided to residents and consumers was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The interviewed GP verified that medical input was sought in a timely manner that medical orders are followed, and care is implemented promptly. The community key worker interviewed reported satisfaction with the care provided. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<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</p>	FA	<p>The activities programme is provided by two activities coordinators who are both undergoing training in diversional therapy. A social assessment and history is undertaken on admission to ascertain residents' and consumers' needs, interests, abilities, and social requirements. Activities programmes are regularly reviewed to help formulate an activities programme that is meaningful to the residents.</p>

<p>to their needs, age, culture, and the setting of the service.</p>		<p>Resident's activity needs are evaluated as part of the formal six monthly interRAI assessments and care plan review and when there is a significant change in the residents' ability, this was evidenced in the records reviewed.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Consumers, residents and families/whanau/EPOA were involved in evaluating and improving the programme through satisfaction surveys and consumer meetings. Residents and consumers interviewed confirmed they find the programme satisfactory. Daily activities attendance records were maintained, and the activities are held separately for each level of care. Residents were observed participating in a variety of activities on the days of the audit.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. The records sampled evidenced that 24-hour care plans were completed for all residents in the dementia unit. Activities are offered at times when residents are most physically active and/or restless. This includes ladies pamper sessions, short walks, one on one conversations, tiki tour, aroma therapy, happy hour, armchair music, collage work, art and craft, foot and spa therapy, block building, reading, puzzles, group exercises nuts and bolts fixing, skittles and there is a fiddle board. The activity coordinator reported that the activities planner is subject to change if required, to meet the residents' needs.</p> <p>Consumers in the psychiatric unit have additional support for their activities through the local district health board support services. Consumers have free access to their unit using a separate entrance. These consumers can access community events and social activities with support.</p> <p>Interviewed consumers and family reported satisfaction with the activities programme in place.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' and consumers' care were evaluated on each shift and reported in the progress notes by the care staff. Any changes noted were reported to the RN, this was confirmed in the records sampled. The RNs document in the progress notes at least weekly for the dementia residents and on daily for the psychogeriatric residents and more frequently as determined by the residents' condition. The mental health support workers in the psychiatry unit document in the progress notes daily and any concerns are reported to the RNs. Three monthly reviews were completed by the psychiatrist. Consumer's recovery plans were reviewed with the support of the mental health key workers, who complete the required outcome measurement tools.</p> <p>Formal care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents' or consumers' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. The short-term care plans</p>

		were consistently reviewed, and progress evaluated as clinically indicated. The consumers and families/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes.
<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	Residents and consumers are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including referrals to mental health team, psychiatrist, dietitian and wound nurse specialist. The consumer and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals were attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate, as verified by the interviewed family.
<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 are documented policies and procedures for the management of waste and hazardous substances. Domestic rubbish is secure and removed as per council requirements. There is additional outdoor storage for garden equipment and tools. Staff have access to the required personal protective equipment (PPE) and were observed using PPE appropriately. Sharps containers were available in the clinic and are removed and replaced by an external provider. Domestic chemicals and medications are securely stored. Oxygen cylinders are secured. There have been no reported adverse events regarding waste or hazardous substances. The management of waste and hazardous substances is included in staff orientation and discussed at staff meetings as required.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building was purpose built and separation between the secure areas and the mental health unit was completed in January 2019. The director is responsible for the maintenance and improvements. Maintenance is addressed in a routine and ongoing manner. Records of maintenance requests are maintained and confirmed that they are addressed. Generalised wear and tear of the building and floor surfaces is monitored and addressed. Internal corridors are wide with safety rails.</p> <p>The current building warrant of fitness is displayed. A contracted company completes the certification of compliance through monthly inspections, maintenance and reporting procedures. Electrical equipment is tagged and medical devices are calibrated.</p> <p>Health and safety requirements are being maintained, including hazard identification. Environmental health and safety is monitored through internal audits of the premises each month. The safety</p>

		<p>checklist covers the entire facility and corrective actions are implemented.</p> <p>There are easily accessible, and secure, outdoor areas with well-maintained gardens. Residents and consumers were sighted moving around safely both indoors and outdoors. All furniture and fittings are replaced as needed. Interviews with consumers and family/whanau members confirmed the environment is suitable to meet their needs. .</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is an adequate number of toilets and shower facilities to meet the needs of the residents and consumers. Toilet and showering facilities are shared, with the exception of two bedrooms in the mental health unit which have ensembles. Each bedroom has a hand basin. Hot water is routinely monitored and records confirmed that the temperature remains consistent and within recommendations. Wall linings in the wet areas are monitored for water tightness. There are two staff/visitor toilets.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single occupancy. Rooms have sufficient space to accommodate personal items, equipment and for the resident/consumer to move around safely. Rooms include adequate storage with a built-in wardrobe in each room. Family and consumers interviewed confirmed satisfaction with the bedrooms rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has numerous communal spaces and dining areas. Communal areas are well furnished and spacious. Quiet smaller communal areas are available. Corridors and walk ways are wide. Residents and consumers were observed enjoying a number of communal and quiet areas. Outdoors areas have raised gardens, sufficient seating and shade cloths.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>There are documented processes for the management of cleaning and laundry. This includes daily task sheets for all cleaning and laundry duties. There are designated laundry and cleaning staff. The laundry has identified clean and dirty areas and a safe and sheltered area for drying. Laundry and</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>cleaning products are provided by an external contractor and labelled. There are secure areas for all chemicals to be stored. The cleaner's trolley is stored in a designated cupboard when not in use.</p> <p>Cleaning and laundry services are monitored through routine internal audits and satisfaction surveys. Consumers and family/whanau interviewed confirmed satisfaction with the cleaning and laundry service. On observation, the laundry was tidy and all areas throughout the facility appeared clean.</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>The approved fire evacuation plan was sighted. The plan was updated when the mental health unit was built. Trial evacuations are completed every six months as required. Records of fire drills sampled confirmed good staff attendance, including night staff. Fire equipment is displayed and maintained. Emergency evacuation procedures are displayed throughout the building. There are smoke alarms in each area. The sprinkler system is routinely checked.</p> <p>There are sufficient supplies of emergency equipment. This includes water, food, first aid supplies and a civil defence kit. Extra blankets are available and gas is supplied to the kitchen for cooking. The building has emergency lighting. All staff have a first aid training. Emergency procedures are included in staff orientation and revisited during regular staff meetings.</p> <p>There are call bells in each bedroom, bathrooms and toilets. These are routinely checked during environmental internal audits. There are security lights outside the building and security cameras inside. The dementia area is secure. Staff conduct security checks each evening.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The building is ventilated and heated appropriately. A combination of heating appliances is installed. All bedrooms have an external window of normal proportions.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	<p>FA</p>	<p>Sunhaven has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the DHB infection control specialist. The infection control programme and manual were reviewed annually.</p> <p>The registered nurse is the designated IPC officer, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the</p>

<p>appropriate to the size and scope of the service.</p>		<p>facility manager, and acting clinical manager, and tabled at the quality meeting and two monthly in staff meetings. This committee includes the facility manager, IPC officer, the GP, infection control specialist from the local DHB and representative from the care staff.</p> <p>There was signage at the main entrance to the facility requesting anyone who has flu like symptoms or has been unwell with an infectious condition in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. The organisation minimised the risk of COVID-19 by ensuring rostered staff remained within the same 'bubble'.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC officer has appropriate skills, knowledge, and qualifications for the role. The IPC officer has completed the infection prevention and control online training as verified in training records sighted. Additional support and information are accessed from the infection control team at the local DHB, the community laboratory, the GP and public health unit, as required. The IPC officer has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC officer confirmed the availability of resources to support the programme and any outbreak of an infection, adequate resources sighted onsite.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed within the past year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. There are processes in place to isolate infectious residents when required. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff had received education on infection prevention and control at orientation and ongoing education sessions yearly and per rising need for example, additional infection control education was provided during the COVID-19 pandemic</p>

<p>education on infection control to all service providers, support staff, and consumers.</p>		<p>lockdown period. Education is provided by an infection control specialist from the local DHB and the acting clinical manager. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. Education attendance records were maintained, and high staff attendance levels were demonstrated.</p> <p>Education with residents is on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and thrombophlebitis. The IPC officer reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, FM, and IPC committee.</p> <p>There was no infection outbreak reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Sunhaven actively works to minimise restraint use. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints. There were no enablers in use at the time of the audit. The restraint officer provides support and oversight for restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. There is a secure unit with access into the dementia unit controlled by access swipe fobs.</p> <p>On the day of audit, one resident was using restraint and none using enablers. The types of restraints in use were the bedrails and the lap belt for the same resident. These were approved as a last resort as all other alternatives had been trialled. This was confirmed in the restraint approval group meeting minutes, resident's records sampled and from interviews with staff. The services' policy supports the use of the least restrictive type of restraint to maintain the resident's safety.</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>	<p>FA</p>	<p>The restraint committee consists of the FM, acting clinical manager, GP, restraint officer, health and safety representative, activities coordinator, and the director. The restraint approval group consists of the FM, restraint officer and the GP. This group is responsible for the approval of the use of restraints and the restraint processes. Clear lines of accountability were documented in the restraint officer's position description and in the restraint minimisation policy and procedure. The restraint in use was approved, and the overall use of restraints was being monitored and analysed. This was evidenced in the documents sampled including the restraint use consent form. Evidence of EPOA involvement in the decision making was on file. Use of a restraint was documented in the care plan.</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>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of this Standard. The RN undertakes the initial assessment with the restraint officer's involvement, and input from the resident's family/whānau/EPOA. The RN and restraint officer interviewed described the documented process. Family confirmed their involvement. The GP was involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives, and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of resident who was using restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised, and the restraint officer described how alternatives to restraint are discussed with staff and family members, for example low beds and regular visual checks of residents.</p> <p>Records sampled confirmed that frequent monitoring was completed to ensure the resident remained safe while using restraint. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes to ensure dignity and privacy are respected.</p> <p>There is a current restraint register that was updated every month and reviewed at each restraint approval group meeting occurring three- monthly. The register was reviewed and information about the resident who was currently using a restraint is documented with enough information to provide an auditable record.</p> <p>Staff have received training on the restraint policy and procedure at orientation and in related topics, such as challenging behaviours management and annual restraint use competency checks. Staff interviewed understood that the use of restraint was to be minimised and how to maintain safety when in use.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of the resident's file showed that the use of restraint was reviewed and evaluated during care plan and interRAI reviews. Three monthly restraint evaluations were completed at the restraint approval group meetings. Sampled documents confirmed EPOA's involvement in the evaluation process. The evaluation covers all requirements of the Standard, including the impact and outcomes achieved, and documentation completed as required.</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>	FA	<p>The restraint committee undertakes a three-monthly review of all restraint use which includes all the requirements of this Standard. Three monthly restraint meetings and reports are completed, and individual use of restraint use was reported in the quality and staff meetings. Minutes of meetings sampled confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint education and feedback from the doctor, staff and families. Results from a three-monthly internal audit also informed these meetings. Records sampled, minutes and interviews with the restraint officer confirmed that the use of restraint has been reduced over the past year.</p>

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.

No data to display

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
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The organisation has implemented a comprehensive process for documenting and implementing a wide range of continuous improvements. A register of quality improvements is maintained. This included 32 quality improvements in the year 2019 and 14 improvements for the year 2020 to date. Any change or improvement is being documented using a quality improvement cycle and is managed by the clinical manager and the facility manager. Examples of additional improvements were sampled and included tool boards placed around the facility for the dementia/psycho-geriatric residents. These have provided the residents with additional activities to reduce episodes of behaviour. Additional specialist training for the mental health support workers resulting in improved opportunities to support recovery. Additional cultural support for a Samoan resident which has resulted in an improvement in their communication abilities. Increased correspondence and communication with family/whanau during the lock down period which helped to reduce family/whanau concerns when they were unable to visit. Additional dietician reviews every three months. This includes an in-service with the residents. The individual eating habits and nutritional needs for each resident is discussed. Records sighted confirmed improvement in weight management for the clients' which had been discussed. A quality improvement plan is also in place to reduce polypharmacy. This project involves an annual review with the pharmacist with clear</p>	<p>The implementation of a wide variety of quality improvements is resulting in improved outcomes for residents/consumers.</p>

		targets set for reducing the number of medications residents are prescribed.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>Sunhaven has continued with the New Zealand Nursing Council approved competency assessment programme which has been operational since November 2016. This programme has been very successful and has now been extended to include two providers. The organisation is available to support nursing students. There were third year nursing students on site during the audit completing their final placements.</p> <p>An annual in-service education plan is developed. There are up to 28 in-service training sessions provided over a 12-month period. Training is comprehensive and provided by a range of internal and external provider/educators and specialists. Additional topics have included encouraging best practice in aged care, mental health study days, leadership in aged care and common side effects of medication. Attendance at additional education is high amongst staff. For example, the most recent education on challenging behaviour was attended by 28 of the 40 staff members. Staff are remunerated and given time off to attend training.</p> <p>Additional education programmes for families and staff have also continued and are facilitated by the Alzheimer's society. Staff also participated in a mental health study day in February 2019 and again in January 2020 which was presented by the district health board clinical nurse specialist in mental health. This training was attended by all the level four mental health support workers and two registered nurses.</p> <p>The acting clinical manager is receiving weekly external mentoring and supervision from a clinical nurse specialist in aged care and all the registered nurses are provided with leadership training.</p> <p>Training sessions are evaluated with information used to improve quality of further training sessions. Staff state that the information is useful and they are able to improve practice as a result of the training.</p>	<p>The organisation is committed to providing and supporting staff with ongoing education which exceeds the requirements of this standard and their agreement with the district health board. This has helped retain staff and improve practice.</p>

End of the report.