# Sunrise Healthcare Limited - Jervois Residential Care

## 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Sunrise Healthcare Limited

**Premises audited:** Jervois Residential Care

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

**Dates of audit:** Start date: 6 June 2018 End date: 7 June 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 38

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Jervois rest home and hospital is one of three facilities owned by Sunrise Healthcare. The facility provides rest home and hospital level of care for up to 46 residents. On the day of the audit there were 38 residents.

A general manager of operations is responsible for the daily operations of the service. She is supported by a clinical manager.

The residents and relatives spoke positively about the care including the meals and activities provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

This certification audit identified areas for improvement around corrective actions, essential notifications, training attendance, care plan interventions and referrals.

## Consumer rights

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

Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Residents and families are informed regarding the Code and staff receive training about the Code.

The personal privacy of residents is respected. Care plans reference the individual values and beliefs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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

Services are planned, coordinated and are appropriate to the needs of the residents. A general manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is being established. Data collected is analysed and shared with staff.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. The education and training plan includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week.

## Continuum of service delivery

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

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and plans residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and resident/relative input into care. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for the 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 team and coordinates the activity programme for the residents. 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. Residents and families report satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. 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

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. There is a mix of ensuite and communal toilet/shower facilities. Documented policies and procedures for the cleaning service is implemented with appropriate monitoring systems in place. All personal clothing and linen is laundered off-site. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is at least one staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

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

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. During the audit there were no residents using a restraint or an enabler.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (currently the clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator has completed on-line training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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 | 40 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 88 | 0 | 3 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Jervois Residential Care policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the in-service programme (link 1.2.7.5).  Interviews with seven care staff (three caregivers, one clinical manager/registered nurse (RN), one staff RN, two activities staff) confirmed their understanding of the Code. Seven residents (three hospital including one young person with a disability and four rest home) and three relatives (one hospital and two rest home) interviewed, confirmed that staff respect privacy, and support residents in making choices. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in seven of seven resident files reviewed (three rest home and four hospital including one younger person). Specific consents were on resident files as applicable such as influenza vaccines. Resuscitation status and advance directives were appropriately signed. Medically indicated not for resuscitation status (as applicable) were in place for residents deemed unable to make an informed choice. Copies of enduring power of attorney (EPOA) were present and activated as required.  An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Family and residents interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  All residents’ files reviewed had signed admission agreements on file. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirmed they are aware of their right to access independent advocacy services. One resident interviewed, indicated that he advocates for the residents. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents’ family/whānau and chosen social networks.  The HDC advocacy service is an invited speaker at resident/family meetings and staff training on the Code and the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  There is a complaint register that includes complaints received, dates and actions taken. The general manager signs off each complaint when it is closed. There is evidence of lodged complaints being discussed in the staff meetings.  Three complaints have been received in 2018 (year-to-date). All three complaints were reviewed and indicated that complaints are being managed in a timely manner, meeting requirements determined by HDC. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code are displayed throughout the facility. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. Three rooms are double rooms with a privacy curtain to separate the bedrooms. Residents and families have consented to sharing a room.  Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.  Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Māori health plan policy for the organisation provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged.  As per the Māori health plan policy, the resident’s care plan is expected to indicate cultural, religious and spiritual beliefs. One resident at the facility identifies as Māori. He was observed listening to te reo Māori on his television and reported that he also speaks te reo Māori. Pictures of whānau were posted in his room. He reported that he advocates for the other residents. There was no indication in his care plan that this resident identified with his Māori culture (link 1.3.5.2). The resident was interviewed and reported that his cultural needs were being met. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Individual beliefs or values are discussed and incorporated into the care plan, evidenced in six of the seven care plans reviewed (link 1.3.5.2). Six monthly care plan reviews assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents’ values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. Monthly staff meetings include discussions around professional boundaries and concerns as they arise. Three managers (general manager, clinical manager, facility manager) provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service promotes evidence-based practice and encourages good practice. Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.  Registered nursing staff are on-site 24 hours a day. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.  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, three hours per week with the support of a physiotherapy assistant for four to six hours a day, five days a week. All new residents are assessed by the physiotherapist. Transfer plans are developed and posted in each resident’s room. The falls prevention programme includes implementing aspects of the Otago falls prevention programme.  The service has links with the local community and encourages residents to remain independent. Activities staff lead group activities and also provide one-on-one visits with residents. Residents who are able, are encouraged and supported to remain active in their communities.  Adverse event data is collected and collated. Action plans are implemented to minimise risk, and processes are reviewed and evaluated. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 15 adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member. Monthly resident meetings provide a venue where issues can be addressed.  There is an interpreter policy in place and contact details of interpreters were available. Families and staff are used in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Jervois Residential Care provides care for up to 46 residents. This is one of three aged care facilities owned and managed by Sunrise Healthcare. The service is certified to provide hospital (medical, geriatric) and rest home level care. All resident rooms are dual-purpose.  On the day of the audit, there were 38 residents. This included 16 rest home level and 22 hospital level residents. In addition to the aged residential care contract, one resident was on the young persons with a disability (YPD) contract.  A 2018 business plan is documented for the service. The quality and risk management plan (2018) identifies a vision, mission and eight objectives with anticipated outcomes. Business goals and quality/risk objectives are regularly reviewed and discussed at the facility meetings.  The general manager is an RN who provides oversight to all three Sunrise Healthcare aged care facilities. She has worked as a manager in aged care for the past five years with the last three years with Sunrise Healthcare where she is on-site approximately one – two days a week. She is supported by a full-time clinical manager/RN. Both the general manager and the clinical manager have maintained a minimum of eight hours of professional development relating to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical manager/RN covers during the absence of the general manager. She has been in her role since December 2017, has a post-grad cert and is a New Zealand trained RN. She has been a RN at Jervois for the last four years. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management system is being established. Quality and risk performance is reported. Discussions with the general manager, clinical manager and staff (seven care staff, one cleaner, one cook, one maintenance) reflected staff involvement in quality and risk management processes.  Resident and family meetings are held each month. Minutes are maintained. Annual resident satisfaction surveys were last completed in March/April 2018. Results have been collated and discussed with staff.  The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed by a policy review committee. Work remains underway to replace policies that were implemented prior to the purchase of the facility approximately one year ago, with all policies on a two-yearly schedule.  The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. An internal audit programme is being implemented. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are documented when opportunities for improvements are identified but evidence was missing to indicate their implementation.  Health and safety policies are implemented and monitored by a health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements can be made.  Falls prevention strategies are in place including sensor mats, and intentional rounding. A physiotherapist assesses all new residents and has developed comprehensive transfer plans, which have been reported as being successful in helping to reduce the number of falls. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by a manager when complete.  A review of twenty accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are completed for any suspected injury to the head.  Essential notifications are understood by the general manager, although Section 31 reports were not completed for two instances where the police were involved to help find a missing resident. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (three RNs, three caregivers) included the recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.  The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan. There is an attendance register for each training session. Staff attendance is less than 50% for mandatory training. Staff are required to complete written core competencies as part of their induction to the service. They also complete a competency questionnaire after attending in-services (eg, manual handling, code of rights, hand washing, fire evacuation).  Performance appraisals were up-to date in all staff files reviewed of staff who had been employed for one year or longer.  Registered nurses are supported to maintain their professional competency. Five of six registered nurses have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication, syringe driver, wound and insulin competencies. Nursing staff also attend specific in-service training programmes (eg, delirium, advanced care planning, wound management and care). |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The clinical manager/RN is available five days a week (Monday – Friday) and is supported by the general manager/RN one – two days a week.  There are three wings. The kauri wing (11 rest home and 3 hospital), nikau wing has 11 of 13 beds occupied (9 Hospital and 2 rest home) and kowhai wing has 13 of 17 beds occupied (9 hospital and 4 rest home). There is a minimum of one staff RN on duty 24 hours a day, seven days a week. Five caregivers are rostered on the AM shift and four caregivers are rostered on the PM shift. Two caregivers work alongside the RN during the night shift.  Activities staff are available five days a week with an additional short shift caregiver on the weekends to assist with activities. There are separate cleaning staff seven days a week and laundry are taken off-site.  Staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide adequate support. Residents and family interviewed also reported there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access.  Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Residents’ files reflect service integration with files documented in both hard copy and electronic copy (Lee care). Archived residents’ files are stored securely. Electronic information is backed up using cloud-based technology. All computers are individually password protected. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to admission. Seven admission agreements of long-term residents were reviewed and align with all contractual requirements. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses have been assessed for medication competency on an annual basis. Caregivers complete competency assessments for the checking of medications. Education around safe medication administration has been provided. The service uses robotic rolls, and these are checked on delivery fortnightly, against the paper-based medication charts. Standing orders are not used. Three rest home and two hospital level of care residents were self-medicating and had self-medicating competencies in place authorised by the GP and reviewed three monthly. Self-administration is monitored each shift for resident compliance. The medication fridge is monitored daily. All medications are stored safely. Eye drops were dated on opening. All hospital level stock was within the expiry dates. All medications are prescribed for individual rest home residents.  All 14 medication charts reviewed (four rest home and ten hospital level of care) met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. All medications had been administered as prescribed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals and baking are prepared and cooked on-site by a cook (currently progressing through chef qualifications), who is supported by morning and afternoon kitchenhands. There is a four-weekly menu which has been reviewed by a dietitian May 2018. The main kitchen is adjacent to the hospital dining room and meals are served from the bain marie directly to the residents in the dining room. Meals are transported in a bain marie to the rest home dining room and served.  Resident dietary needs are known with individual likes and dislikes accommodated. Dietary requirements (diabetic desserts vegetarian and pureed foods), cultural and religious food preferences are met. The cook is notified of any residents with weight loss. Additional or modified foods are also provided by the service. Staff were observed assisting residents with their meals and drinks.  Fridge, chiller and freezer temperatures are taken and recorded daily. End cooked food temperatures are taken and recorded on each meal. Dishwasher rinse and wash temperatures are taken and recorded. Cleaning schedules are maintained. Chemicals are stored safely. Kitchen staff were observed to be wearing correct personal protective clothing. The food control plan was submitted 20 August 2018. Food services staff have completed training in food safety and hygiene.  Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an initial assessment on admission, including applicable risk assessment tools such as falls and pressure injury risk assessments. Initial interRAI assessments had been completed for all residents within 21 days of admission. Resident needs and supports are identified through the ongoing assessment process in consultation with family/whānau and significant others. The long-term care plans in place reflected the outcome of the assessments (link 1.3.5.2). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident care plans reviewed (paper-based and electronic) were individualised and included resident goals. Not all care plans reflected the resident’s current supports/needs. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.  There was evidence of allied health care professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian and mental health services for the older person. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, GP, dietitian or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the progress notes of the resident electronic file.  Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for four residents with wounds including three chronic wounds which were linked to the care plans. There were no pressure injuries on the day of audit. The GP and district nurse had been involved in the wound management of two chronic ulcers.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.  Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, neurological observations and challenging behaviour.  Acute care needs (on the electronic resident system) document appropriate interventions to manage short-term changes in health. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service has a qualified registered diversional therapist (DT) who oversees the activity programme across two Sunrise Healthcare facilities. She works two days a week at Jervois and is supported by an activity assistant who works Monday, Wednesday and Friday. The integrated rest home and hospital activity programme is from 9.00 am to 4.00 pm Monday to Friday. The activity team provide individual and group activities in the rest home (afternoons) and hospital (mornings) to meet the recreational preferences of the resident groups. The programme includes (but not limited to); news group, exercises, board games, arts and crafts, flower arranging, word games, cooking, knitting club and jewellery making. Community visitors include churches, inter-home visits, pet therapy, entertainers with happy hour and pre-school children. There are weekly outings in the shared Sunrise Healthcare van. The van drivers and activity team hold current first aid certificates. Residents enjoy scenic drives to the airport, beaches and outings to community cafes, RSA and other rest homes for games and competitions. One-on-one activities such as individual walks, massage, reading and pampering occur for residents who are unable or choose not to be involved in group activities. A music therapy volunteer visits fortnightly for singing, playing guitar and music appreciation.  Activities provided are appropriate to the needs, age and culture of the residents. The younger person is invited to attend group activities of their interest and also attends community groups such as the gym and library and has a social worker to visit and accompany them on outings as desired.  An activity assessment and plan are completed on admission in consultation with the resident/family (as appropriate).  Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through meetings, surveys and one-on-one feedback from residents and families. Residents interviewed spoke positively about the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RN within three weeks of admission and long-term care plans developed. The resident and/or relative and health professionals as required, are involved in the evaluation process. Long-term care plans had been evaluated at least six monthly for all long-term residents. The GP reviews residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and acute care needs forms. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | PA Moderate | Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services, however, a referral for re-assessment for level of care had not been initiated.  There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Chemicals are stored in locked areas and safety datasheets are available. There is a chemical spills kit available. Relevant staff have completed chemical safety training. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 30 July 2018. The building has two levels with the basement area for staff only, storage and laundry space. There is a lift between the floors with code access.  The maintenance person (also a health and safety representative) works two days a week on-site at Jervois and two days a week at another Sunrise Healthcare facility. He is available on-call for facility matters. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Calibration and functional checks of medical equipment is completed. Hot water temperatures in resident areas are monitored and are below 45 degrees Celsius.  Rooms are refurbished as they become vacant. The facility corridors have sufficient space for residents to safely mobilise using mobility aids. There is safe access and ramps to the outdoor areas and deck. Seating and shade is provided.  The care staff and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are three rooms with full ensuites and four with shared ensuites. All resident rooms have hand basins. There are adequate numbers of communal bathrooms/toilets in each wing. Communal toilet facilities have a system that indicates if it is engaged or vacant. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are three double rooms and all others are single. Privacy curtains were in place in the double rooms. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Bedrooms have external windows allowing adequate light and ventilation. Residents and families are encouraged to personalise their rooms. This is evident on audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include a rest home and hospital dining room with a large main lounge where most activities take place. There are additional lounges where small group or individual activities can take place. Seating and space is arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are designated cleaning staff seven days a week. Cleaning trolleys are well equipped and kept in locked areas when not in use. The service conducts regular reviews and internal audits of cleaning services to ensure these are safe and effective. All personal clothing and linen is laundered off-site at a commercial laundry. Dirty laundry is transported by lift to the basement and external shed where it is collected. Clean laundry is delivered into the disused laundry area for distribution. There was adequate clean linen available on the day of audit. There is one washing machine for use if required for delicates. Residents interviewed were overall happy with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster policies and procedures to guide staff. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place, which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on-site and are adequate for three days. Electronic call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is kept locked from dusk to dawn. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and external opening windows for ventilation. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control coordinator is an RN currently on leave. The clinical manager (CM) is covering the role in her absence and is responsible for the collation of infection events. Infection events are collated monthly and reported to the monthly infection control meeting. The 2017 infection control programme has been reviewed May 2018 and is linked to the quality system. Infection quality goals are incorporated into the overall quality plan.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The CM has completed on-line MOH infection control education January 2017. The infection control committee are representative of all areas (RNs, caregivers, housekeeping and food services) who meet monthly.  The infection control coordinator/CM has access to the quality nurse leader at the DHB, local laboratory, the DHB infection control nurse specialist and public health departments, gerontology nurse specialist and GPs. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff read and sign education content if they have not attended scheduled in-service. Hand hygiene competencies are completed on orientation and are repeated at six monthly intervals.  Resident education is expected to occur as part of providing daily cares as appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator/CM collates information obtained through surveillance to determine infection control activities and education needs in the facility. Data is collated and sent to an external benchmarking company. Benchmarking results are displayed for staff. Definitions of infections in place are appropriate to the complexity of service provided. Infection control data is discussed at both the infection control meetings and staff meetings. Trends are identified, and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. The restraint coordinator is an RN, who was on leave during the audit. The clinical manager was interviewed in her absence.  There were no residents using restraints or enablers during the audit. Procedures are in place to follow if restraint is used.  Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours (link 1.2.7.5). |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The resident satisfaction survey identified several areas for improvements, but there were no corrective action plans documented to address these areas. An internal auditing programme is in place with evidence to support that the audit schedule is being followed. Corrective action plans are developed where indicated. Five corrective action plans reviewed indicated that only one of the five plans were implemented. | i) Corrective action plans were not developed post the 2018 resident satisfaction survey where improvements were identified.  ii) Corrective action plans were developed around the internal auditing programme, but documentation did not evidence their implementation. | i) Ensure corrective action plans are developed around the patient satisfaction survey where areas have been identified requirement improvements.  ii) Ensure that corrective action plans are implemented.  90 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | The general manager interviewed, understands her statutory and regulatory obligations in relation to essential notification report with examples provided, although she was unaware that a section 31 report needed to be completed for any police investigation involving a missing resident. | Police were involved in two instances where a resident was missing (April 2018, May 2018) but section 31 reports to notify the Ministry were not completed. | Ensure Section 31 reports are completed for any police investigation that involves a missing resident.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Staff are provided with more than eight hours annually of in-service education. Education is frequently followed with a competency questionnaire. A selection of in-services are mandatory with less than 50% of staff attending. | Staff attendance at mandatory in-service education is below 50%. | Ensure staff participate in the mandatory in-service education programme.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Two of seven care plans reflected the outcomes of the assessment process and supports/needs to meet the goals. Five resident care plans did not reflect interventions to support all the resident’s current health status. | 1.Two hospital level residents’ care plans did not interventions to support all current needs as follows; (i) no pain management plan for chronic pain, and (ii) no pain assessment or plan for painful knees as per physiotherapy notes.  2.Three rest home level residents’ care plans did not reflect current supports/needs as follows; (i) no pain management plan for resident with known pain and on regular and ‘as required’ analgesia, (ii) the care plan did not identify a resident as high falls risk and there were no documented falls prevention strategies in place. Interventions post falls assessment had not been included in the care plan, and (iii) there was no risk alert on the care plan of a resident who has absconded several times and the care plan did not identify the use of a wandatrak.  3. One Māori resident who identified with his culture did not have this indicated in his care | Ensure all care plans reflect the current supports/interventions to meet the resident’s needs.  60 days |
| Criterion 1.3.9.1  Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained. | PA Moderate | A resident with repeat absconding had not been referred to a needs assessor for re-assessment for change in level of care. | The service had received GP and mental health services review and recommendation for a resident with changes in cognitive status and absconding (link 1.2.4.2). Interventions such a wandatrak (link 1.3.5.2) and 15-minute watch had been implemented. The residents condition had not improved and an interRAI had not been completed for significant change in health status and a re-assessment for level of care had not been requested. This was done on the day of audit, therefore the risk is reduced from high risk to moderate risk. | Ensure referrals are initiated for significant changes in health and interRAI assessments are completed for significant changes in health.  7 days |

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

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

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

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

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End of the report.