Sunrise Healthcare Limited - West Harbour Gardens

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.

The specifics of this audit included:

Legal entity:	Sunrise Healthcare Limited
Premises audited:	West Harbour Gardens
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 5 June 2018 End date: 6 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: 60	

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

West Harbour Gardens 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 74 residents including younger people with disabilities. On the day of the audit there were 60 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 training attendance and care plan evaluations. The service has been awarded a continuous improvement for low infection rates.

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.

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 ongoing training about the Code.

The personal privacy and values of residents are respected. Individual care plans reference the cultural needs 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 implemented. Data collected is analysed and shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

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

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

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 viewed 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. The kitchen is well equipped for the size of the service. 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

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 with access to communal 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

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. A register is maintained. During the audit four residents were using a restraint and one resident was using bedrails as an enabler.

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.		All standards applicable to this service fully attained with some standards exceeded.

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 (clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator has completed online 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	1	47	0	2	0	0	0
Criteria	1	98	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

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	West Harbour Gardens 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 eight care staff (four caregivers, one registered nurse (RN), one diversional therapist, one activities staff, one physiotherapist) confirmed their understanding of the Code. Nine residents (six hospital level including three young persons with a disability and three rest home level) and two relatives (both hospital level and including one who is a family member of a young person with a disability) 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	FA	There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in eight of eight resident files reviewed (two rest home and six hospital including one younger person –YPD with intellectual disability, one YPD with physical disability, one under ACC funding, one respite care, and one younger person under the long-term chronic health condition contract). 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 EPOA were

choices and give informed consent.		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 resident's 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. 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 (link 1.2.7.5).
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. The service is responsive to young people with disabilities accessing the community, resources, facilities and mainstream supports such as education, public transport, and primary health services in the community. 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.

		Two complaints have been received in 2018 (year-to-date) and both were reviewed. One complaint is documented as resolved and the second complaint is under investigation. 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 and the nationwide advocacy service. 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 and advocacy information are displayed throughout the facility. A manager or RN discusses the information pack with residents/relatives on admission. 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 are 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. Young people with disabilities are able to maintain their personal, gender, cultural, religious and spiritual identity, evidenced in all three files reviewed of residents who were young persons with a disability (one intellectual disability, one physical disability, one long-term chronic condition). 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 references local Māori healthcare providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. During the audit there was one resident who identified as Māori living at the facility, who was not available to be interviewed.

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	An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan, evidenced in all residents' files reviewed. Six monthly multi-disciplinary team meetings (link 1.3.8.2) occur to 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. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Two managers interviewed (general manager, clinical 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. A house GP visits the facility two days a week. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed 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, in particular the younger residents. Young persons 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 indicated that family are kept informed. Family members interviewed confirmed they are notified following a change of health status of their family member. Monthly family/resident meetings provide a venue where issues can be addressed. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance. A range of communication methods are available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	West Harbour Gardens residential care provides care for up to 74 residents. This is one of three aged care facilities owned and managed by Sunrise Healthcare. The service is certified to provide hospital (medical, geriatric), rest home and residential – physical/intellectual disability level care. All resident rooms are dual-purpose. On the day of the audit, there were 60 residents. This included 16 rest home level and 44 hospital level residents. Of the 44 hospital residents, eight residents (hospital level) were under the young persons with a disability (YPD) contract (four physical disability, four intellectual disability), three residents (hospital level) was on the long-term chronic conditions contract (LTS-CHC), and one resident (hospital level) was funded by ACC. There was one (hospital level) respite resident. Of the 16 rest home residents all were on the ARCC contract except one on a LTS-CHC contract. Additionally, there were five non-assessed boarders. 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 at West Harbour Gardens where she is on-site approximately three days a week. She is supported by a full-time clinical manager/RN. The clinical manager is a registered nurse who has worked in aged care for five years and has been employed at West Harbour Gardens for two years. 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	FA	The clinical manager/RN covers during the absence of the general manager. A clinical coordinator/RN has recently been appointed but has not yet begun her employment at West Harbour Gardens. She will cover for the clinical manager in her absence with support by the general manager.

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.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported. Discussions with the general manager, clinical manager and staff (eight care staff, three cleaners, one cook, one maintenance) reflected staff involvement in quality and risk management processes. Young people with disabilities have input into quality improvements to the service with examples provided. Satisfaction with choices, decision making, access to technology, aids equipment and services contribute to quality data collected by the service. 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. Areas of improvement have been highlighted with corrective actions documented to indicate improvements required. 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. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (e.g., internal audit results). Corrective actions are signed off when completed. 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 are 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.	FA	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 the clinical manager when complete. A review of 15 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 recorded for any suspected injury to the head. The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. There was evidence of two Section 31 reports completed for pressure injuries.
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. Eight staff files reviewed (three RNs, four caregivers, one physiotherapy assistant) included a 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. Staff are required to complete written core competencies as part of their induction to the service. There is an implemented annual education and training plan. All staff are requested participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session. Staff complete a competency questionnaire following a selection of in-services (e.g., manual handling, code of rights, hand washing, fire evacuation). Caregiver attendance at in-service training is below average. 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. Two of seven registered nurses have completed their interRAI training. Over the last nine months there have been seven RN resignations due to joining the DHB, another care home and one to a private hospital. This left one RN interRAI trained and the clinical manager who have been unable to keep up with the interRAI assessments. 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

		(e.g., delirium, advanced care planning, wound management and care) with high attendance rates.
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 three days a week. A clinical coordinator/RN has recently been employed and begins work on 18 June 2018. There are three wings (Rata, Kowhai and Ngaio) with 24 dual-purpose beds in each wing (note: two certified rooms are currently being used as lounges). The highest level of care is in Kowhai with 22 hospital level residents and one rest home level. Kowhai is staffed with one RN on the AM and PM shifts. Four caregivers (two long shifts and two short shifts) cover the AM shift and two caregivers (long shifts) cover the PM shift with additional assistance from a float caregiver who covers all three wings. Rata (15 hospital, 7 rest home) and Ngaio (7 hospital and 8 rest home) is staffed with one RN on the AM and PM shifts. Two caregivers (one long shift and one short shift) cover each wing with assistance from the floating caregiver. Inclusive in the hospital and rest home numbers described above, there were eight YPD residents located across the three wings: Rata wing: two YPD (one ID and one PD), Ngaio wing: one YPD (physical) and Kowhai wing: five YPD (three ID and two PD) The night shift is staffed with one RN and three caregivers (one for each wing). Currently the service is using an agency for RN cover with reports of high RN turnover. Agency use is 32 hours per week. Efforts are underway to reduce the use of agency staffing. 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 (Leecare). 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. The respite care resident had signed a short-stay agreement. 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. Staff were observed to be safely administering medications. The service uses robotic rolls, and these are checked on delivery against the paper-based medication charts. Standing orders are not used. One rest home resident and one hospital level of care resident were self-medicating and had self-medicating competencies in place authorised by the GP and reviewed three monthly. The medication fridge is monitored twice daily. All medications are stored safely. Eye drops were dated on opening and all stock was within the expiry dates. All 16 medication charts reviewed (four rest home and 12 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,	FA	All meals and baking are prepared and cooked on-site by a qualified cook, 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 main dining room and meals are served from the bain marie directly to the residents in the dining room. Meals are plated and covered with insulated lids and delivered to the

fluids and nutritional needs are met where this service is a component of service delivery.		smaller dining room. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements (diabetic desserts and lactose free diets), cultural and religious food preferences are met. 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 recorded. Inward chilled goods have temperatures checked on delivery. 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 not been completed for two rest home residents within 21 days of admission (link 1.2.7.5). Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. The long-term care plans in place reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote	FA	Resident care plans reviewed (paper-based and electronic), identified support needs as assessed and included resident goals. 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.

continuity of service delivery.		There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian. The care plans for the younger persons reflected the residents individual physical and emotional supports required to maintain their well being. There was evidence of allied health professional involvement in the residents care such as physio, dietitian, community teams and field officers. An initial assessment and initial care plan had been completed for the respite care resident.
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 all current wounds, skin tears and nine residents with pressure injuries (eight facility-acquired including one stage three, four stage two, and three stage one, plus one stage two community acquired). There is a range of pressure injury prevention equipment readily available and in use. The audit identified that the service had a high number of pressure injuries. However, all nine pressure injury documentation was reviewed and all had regular PI assessments completed and pressure relieving equipment in place. The two hourly turns were sighted on the caregivers record. There are residents of higher acuity such as tetraplegic, paraplegic and some reported to be non-compliant with PI interventions. Chronic wounds have been linked to the long-term care plan. There was evidence of wound nurse specialist involvement in the management of wounds. 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, restraint 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	FA	The service has a qualified registered diversional therapist (DT) who oversees the activity programme

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.		across two Sunrise Healthcare facilities. She works two days a week at West Harbour and is supported by an activity assistant to implement the integrated rest home and hospital activity programme Monday to Friday. The activity team provide individual and group activities in the rest home and hospital to meet the recreational preferences of the resident groups. The programme includes (but is not limited to); news group, exercises, board games, arts and crafts, sensory activities, word games, cooking, knitting club and walking groups. Community visitors include churches, inter-home visits, pet therapy, entertainers, haka groups and Indian choir group. A male volunteer coordinates a men's group, which the younger men enjoy attending. There are weekly outings in the 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. Activities provided are appropriate to the needs, age and culture of the residents. The younger people are invited to attend the group activities of their interest. The activity team make daily contact with the younger people and ensure they have their recreational needs met. They have good family support and go out regularly with family or their support persons to community events and activities. 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 surveys and one-on-one feedback from residents (as appropriate) and families. Residents interviewed were happy with the activities offered. The younger persons were happy the service ensures they continue with community and family outings.
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 relative health professionals are involved in the evaluation process. Long-term care plans had not been evaluated six monthly for three of seven long-term residents (link 1.3.3.3). 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. The paper-based evaluations involved members of the multidisciplinary team and residents/relatives.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And	FA	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. Referral documentation is maintained on resident files.

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.		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. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas and safety datasheets are 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 16 November 2018. The company employs a maintenance person four day a week who reports to the facilities manager/co-owner. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were below 45 degrees Celsius. Rooms are refurbished as they become vacant. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. 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 adequate numbers of communal bathrooms/toilets in each wing. All resident rooms have hand basins. 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	All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Bedrooms have external doors that open out onto the courtyards. 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 large main dining room where most activities take place. There are private lounges in each wing with a computer and skype available in one of the lounges. 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	FA	There are two cleaners on duty each day. Cleaning trolleys are well equipped with cleaning materials and colour coded equipment. Cleaning trolleys are 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 to an external shed where it is collected. Clean laundry is delivered to a clean laundry area. There was adequate clean linen available on the day of audit. Residents and family interviewed, reported satisfaction with the cleaning

which the service is being provided.		and 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. The emergency plan considers the special needs of young people with disabilities in an emergency. 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/clinical manager oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the monthly infection control meeting. The 2017 infection control programme has been reviewed 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	FA	The infection control coordinator has completed on-line MOH infection control education August 2016. The infection control committee are representative of all areas (RNs, caregivers, housekeeping and food services) who meet monthly. The infection control coordinator has access to the quality nurse leader at the DHB, local laboratory, the

resources to implement the infection control programme and meet the needs of the organisation.		DHB infection control nurse specialist and public health departments, wound 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. Hand hygiene competencies are completed on orientation and are ongoing. 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.	CI	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator 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 are in place and 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. The service has been successful in maintaining low rates of infections.

		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. There was one (hospital level) resident using bedrails as an enabler and four (hospital level) residents using restraint during the audit. The resident file of the resident using an enabler was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint (bed rails, lap belts) for safety. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and/or family/whānau are evident. Two residents' files where restraints were in use were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator/RN is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, sighted in both residents' files reviewed. An internal restraint audit monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify monitoring was evidenced on the monitoring forms for the residents' files reviewed. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed every three months, evidenced in both files reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
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	A range of in-services are offered over a calendar year, exceeding eight hours annually. Mandatory in-service training is identified but caregiver attendance is low with attendance numbers consistently lower than 50%.	(i)Caregiver staff attendance at in-service education is below 50%. (ii) The service had a team of eight RNs (seven interRAI trained) up until September 2017. InterRAI assessments were all up-to-date at that time. Over the last nine months there have been seven RN resignations due to joining the DHB, another care home and one to a private hospital. This left one RN interRAI trained and the clinical manager who have been unable to keep up with the interRAI assessments. The service has only been able to recruit newly graduated oversees RNs to replace their experienced RNs who have resigned. The RNs complete orientation and time in their new RN role before being considered for interRAI training. Three RNs are booked and awaiting training, which when completed, will allow for the remaining three new RNs to commence interRAI training. On the day of audit two rest home residents did not have an interRAI completed within 21 days and three hospital residents (including two younger persons) did not have six monthly interRAI assessments completed.	Ensure caregivers attend all mandatory in-service education. 90 days

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Registered nurses are responsible for each stage of provision of care including assessments, development of care plans and evaluations. Not all care plan evaluations had been completed 6 monthly. Due to lack of interRAI trained RNs, not all first interRAI assessments and routine six-monthly assessments had been developed within the required timeframes (link 1.2.7.5)	Two rest home residents had not been at the service long enough for a six-monthly care plan evaluation. Three of five hospital level long-term residents did not have a six-monthly care plan evaluation completed within 6 months (noting two of them were YPD residents, the service completes interRAI for all their residents).	Ensure care plans are evaluated at least six-monthly 90 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	Monitoring systems including surveillance of infections are in place. Infection types meet the standard definitions and the service is benchmarked against similar size facilities. The service has been successful in achieving zero infections over the last five months in both rest home and hospital residents.	In May 2017, the total infection rate across the rest home and hospital was 2.1 per 1000 bed days. The service continued to focus on infection control practice, hand hygiene and topical education. All staff complete hand washing audits on employment and annually. Care staff interviewed confirmed their knowledge around prevention of infections such as frequent hydration rounds, good personal hygiene and early reporting and interventions for suspected infections. The infection control coordinator collates infection types and numbers and submits them to an external benchmarking company for comparison against 22 other facilities of similar size. West Harbour Gardens is one of two facilities in the benchmarking group who have had no infections from January 2018 to May 2018 in the rest home.

End of the report.