

Bupa Care Services NZ Limited - Gladys Mary Rest Home

Current Status: 13 January 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Gladys Mary Rest Home is part of the Bupa group. The service is certified to provide rest home, and dementia level care for up to 38 residents. On the day of the audit there were 20 rest home residents and 16 residents in the dementia unit. Gladys Mary has a new facility manager (RN). The manager has many years experience in aged care and management. Staff turnover remains low. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Gladys Mary. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are improvements required around incident reporting, aspects of care planning interventions and medication management.

Audit Summary as at 13 January 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	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

Consumer Rights as at 13 January 2014

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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 13 January 2014

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.
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Continuum of Service Delivery as at 13 January 2014

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.
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Safe and Appropriate Environment as at 13 January 2014

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.
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Restraint Minimisation and Safe Practice as at 13 January 2014

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.
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Infection Prevention and Control as at 13 January 2014

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.
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Audit Results as at 13 January 2014

Consumer Rights

Gladys Mary endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. There is an improvement required around informing families of all incidents.

Organisational Management

Gladys Mary has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Gladys Mary is benchmarked in two of these (rest home and dementia). Quality actions have resulted in a number of quality improvements for both residents and staff. There is an improvement required around incident reporting documentation. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff and resident input into rostering.

Continuum of Service Delivery

The service has comprehensive admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. There is an improvement required around aspects of care planning documentation.

Medication policies and procedures are in place to guide practice. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around medication documentation.

The activities programme is facilitated by an activities officer. The activities programme provides varied options and activities are enjoyed by the residents. The programme is designed for high end and low end cognitive functions and caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis.

All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

Safe and Appropriate Environment

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for rest home level residents. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has central heating and temperature is comfortable and constant.

Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service remains restraint-free. Staff are trained in restraint minimisation and challenging behaviour.

Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (facility manager) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has previously attended external training prior to commencing with Bupa and is supported by the Bupa quality and risk team. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Bupa Care Services NZ Limited
Certificate name:	Bupa Care Services NZ Limited - Gladys Mary Rest Home
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Gladys Mary Rest Home
Services audited:	Rest home care and Dementia care
Dates of audit:	Start date: 13 January 2014 End date: 14 January 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	36

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	7
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed	6	Number of staff interviewed	8	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	35	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Wednesday, 19 February 2014

Executive Summary of Audit

General Overview

Gladys Mary Rest Home is part of the Bupa group. The service is certified to provide rest home, and dementia level care for up to 38 residents. On the day of the audit there were 20 rest home residents and 16 residents in the dementia unit. Gladys Mary has a new facility manager (RN). The manager has many years experience in aged care and management. Staff turnover remains low. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Gladys Mary. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are improvements required around incident reporting, aspects of care planning interventions and medication management.

Outcome 1.1: Consumer Rights

Gladys Mary endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. There is an improvement required around informing families of all incidents.

Outcome 1.2: Organisational Management

Gladys Mary has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Gladys Mary is benchmarked in two of these (rest home and dementia). Quality actions have resulted in a number of quality improvements for both residents and staff. There is an improvement required around incident reporting documentation. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff and resident input into rostering.

Outcome 1.3: Continuum of Service Delivery

The service has comprehensive admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and

family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. There is an improvement required around aspects of care planning documentation. Medication policies and procedures are in place to guide practice. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around medication documentation. The activities programme is facilitated by an activities officer. The activities programme provides varied options and activities are enjoyed by the residents. The programme is designed for high end and low end cognitive functions and caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis. All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

Outcome 1.4: Safe and Appropriate Environment

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for rest home level residents. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has central heating and temperature is comfortable and constant.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service remains restraint-free. Staff are trained in restraint minimisation and challenging behaviour.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (facility manager) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has previously attended external training prior to commencing with Bupa and is supported by the Bupa quality and risk team. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	40	0	4	1	0	0
Criteria	0	86	0	3	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	5	0	0
Criteria	0	0	0	0	0	8	0	2

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Two of seven rest home, and four of nine dementia incident forms did not identify that family were notified	Ensure documentation reflects that family are informed of incidents unless they request otherwise.	90
HDS(C)S.2008	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			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve	PA Moderate	The following shortfalls were identified in incident forms reviewed; (i) two falls by a resident on the same day were	Ensure incident form documentation is fully completed including follow up assessment.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		service delivery, and to identify and manage risk.		completed on the same incident from. (ii) four incidents resulting in injury, identified a lack of documented assessment by the registered nurse on the incident form or progress notes (it was noted the incident form identified by the writer that the RN was informed and completed an assessment); (iii) two incident forms identified the resident had hit their head, however there was no documented evidence of neuro obs completed as per policy.		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Two of three dementia resident files have falls risk identified but not linked to long term care plans. Two of three dementia resident files have incomplete MNAs.	Ensure that identified falls risks are linked to long term care plans. Ensure that residents MNAs are accurately completed.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The following shortfalls were identified; a) three rest home resident files reviewed had no documented RN follow-up in progress notes	a)Ensure that RNs document in the resident progress notes all assessments, and observations and follow up interventions, b) Ensure that	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				following changes to health status or following a fall; b) One dementia unit resident's care plan evaluation recognised a change to his nutritional needs (recent choking incident and change to thickened fluids and soft diet). This was not reflected in the relevant section of his long term care plan.	identified changes at time of care plan evaluations are reflected in changes to relevant sections of the long term care plans.	
HDS(C)S.2008	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.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	a) Five out of 18 medication charts do not have sufficient guidelines for use of prn medication (four in the dementia unit and one in the rest home), b) On review of non-packaged medications stored in medication trolleys, two eye drops were not disposed of after one month of use (dementia unit); c) One signing sheet for non-packaged medication administration had two entries for the same medication for over one month.	Ensure that all prescribed prn medications have guidelines for maximum dose and frequency of use. Ensure that medicine management involves routine checks of non-packaged medicines to check for expiry dates and medications requiring disposal. Ensure that there is one signing sheet per medication.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and COR competency questionnaires. Interviews with four caregivers (two from each unit) showed an understanding of the key principles of the code of rights.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

D6, 2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights.

On entry to the service, the manager discusses the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available around the facility.

Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Interviews with six rest home residents identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Interviews with three relatives confirmed they are informed of the code of rights.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA
Evidence: <p>There is a confidentiality and resident privacy policy. The manager is the privacy officer. During the tour of the facility, respect for privacy and personal space was demonstrated. Resident files are held in a locked cupboard in the rest home and a locked cupboard in the dementia unit. Interview with four caregivers (across morning and afternoon shift) could explain ways resident privacy is maintained. Interviews with six rest home residents confirmed that privacy is ensured. The May 2013 resident satisfaction survey identified that 88% residents/relatives stated privacy was either excellent or good. Resident information includes Bupa vision and values. Discussions with six rest home residents and three relatives were positive about the service in respect of considering and being responsive to meeting values and beliefs. D4.1a Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery (confirmed interview). An initial care planning meeting six weeks after admission is carried out, whereby the resident/family are invited to be involved - cultural/religious needs would be again considered at this time. Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, getting up, having breakfast in bed, meal times and meal alternatives) and that staff are obliging around choice. Care plans reviewed identified specific individual likes and dislikes. The four caregivers interviewed could describe examples of giving residents choice including, what time they would like to get up and go to bed, if they would like a shower or not, what they would like to wear and choices about food and activities. There is a question around 'choice' in the May 2013 resident satisfaction survey, 80% of residents stated excellent or good. A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training was last delivered in March 2013 (seven staff attended). D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains</p>

privacy and individuality. Person centred care/individuality and independence training is provided to staff annually.

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Personal belongings are documented and included in resident files.

E4.1a: Two families interviewed from the dementia unit stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA
Evidence: A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e) D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa's facilities. The ADHB tikanga best

practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility.

Gladys Mary has an attachment to the policy that relates specifically to their area. Local Iwi and contact details of tangata whenua are identified. The chaplain is also a resource person. Special events and occasions are celebrated at the home. This could be described by staff, residents and families interviewed.

Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process. There are currently three residents that identify as Maori in the dementia unit [one file reviewed of a resident that identified as Maori included cultural consideration/needs and involvement of whanau].

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member's stay/care.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan.

Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'.

Discussions with relatives all identified that values and beliefs were considered. Discussion with six residents all stated that staff took into account their culture and values.

D3.1g The service provides a culturally appropriate service by ensuring cultural requirements of the residents are understood and considered when providing care to residents.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

Bupa provides a quarterly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. These were sighted at Gladys Mary. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Gladys Mary is currently benchmarked in two areas (rest home, and dementia). A quality improvement programme is implemented that includes performance monitoring. Graphs and data is provided to Gladys Mary staff on the noticeboard and there are examples of corrective actions completed when trends are evident or areas are above the benchmark, i.e.: falls were above the benchmark in October 2013 in the rest home. A quality action form has been established and falls reduced in November.

Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. These are shared with Gladys Mary. Bupa has robust quality and risk management systems and these are implemented at Gladys Mary supported by a number of meetings held on a regular basis.

ARC A2.2: Services are provided at Gladys Mary that adhere to the health & disability services standards.

D1.3: all approved service standards are adhered to.

At an organisational level, a policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. Policies are signed off as read by staff at Gladys Mary. A number of core clinical practices also have education packages for staff, which are based on their policies, and these are implemented at Gladys Mary.

There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.

Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Gladys Mary. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), Gladys Mary is part of this. There is a dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. An example of one sited was as actioned at Gladys Mary June 2013.

Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurse's education day and education session at monthly meeting.

ARC D17.7c There are implemented competencies for care workers, enrolled nurses and registered nurses. Standardised annual education programme, core competency assessments and orientation programmes have been implemented at Gladys Mary. Competencies are completed for key nursing skills at Gladys Mary including (but not limited to); a) moving & handling, b) wound care, c) sub cut fluids, d) assessment tools, and e) medication. RNs have access to external training.

Discussions with six rest home residents and three relatives were positive about the care they receive.

Gladys Mary has gone through many changes in the past 18 months- A new manager, clinical manager (Apr13), and the opening of a new dementia service. The facility has had a stable senior staff for just over a year. This has helped to establish the new dementia wing and progress the service with new ideas and quality improvements for the residents, team and the facility.

Staff stated there is a good positive atmosphere within the facility and there has been a lot of education and work around person centred care especially within the dementia unit. Interviews identify that staff are developing a sound understanding of this philosophy and realising the benefits of this approach to care. This understanding has also resulted in fewer staff incidents over the last year.

Gladys Mary Care home has had no HDC complaints over the last year

There has been a huge improvement on the Quality Improvement within the facility and the environment. The staff are committed to Personal Best Programme and have come up with some great initiatives to improve the physical and emotional wellbeing of residents.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: PA Low

Evidence:

Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.

The relief manager interviewed stated that they record contact with family/whanau on the family/whanau contact record.

Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident.

Incident forms reviewed for January 2014 (to date) and December 13 identified that in five of seven rest home, six of nine dementia incident forms

identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in Oct 2013 at Gladys Mary with a result of 100%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.
D16.4b All three relatives interviewed stated that they are always informed when their family members health status changes.

At an organisational level, a residents/relatives association provides a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. Newsletters were in place at Gladys Mary. Interpreter policy and contact details of interpreters. A list of Language Lines and Government Agencies is available.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D11.3 The information pack is available in large print and advised that this can be read to residents.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: PA Low

Evidence:

Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for January 2014 (to date) and December 13 identified that in five of seven rest home, six of nine dementia incident forms identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in Oct 2013 at Gladys Mary with a result of 100%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.
D16.4b All three relatives interviewed stated that they are always informed when their family members health status changes.

Finding:

Two of seven rest home, and four of nine dementia incident forms did not identify that family were notified

Corrective Action:

Ensure documentation reflects that family are informed of incidents unless they request otherwise.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA
Evidence: <p>The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are procedure information sheets available including (but not limited to); a) minor skin surgery, b) catheterisation, and c) sub cut fluids.</p> <p>Required consent forms and advance directive forms were evident on six resident files (three dementia, three rest home) reviewed.</p> <p>Discussions with four caregivers (two dementia, two rest home) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with the facility manager and the relief manager identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.</p> <p>There is an advance directive policy. The Bupa care services resuscitation of residents policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The "decisions relating to cardiopulmonary resuscitation" pamphlet and advance directive form will be given to the resident and completed. The medical resuscitation treatment plan and resuscitation advance directive will be completed as soon as possible after admission (no more than six weeks).</p> <p>Completed resuscitation treatment plan forms were evident on all six resident files reviewed. The service is working through ensuing all files evidence written discussion with family.</p> <p>D13.1 there were six admission agreements sighted.</p> <p>D3.1.d Discussion with three family (two dementia, one rest home) identified that the service actively involves them in decisions that affect their relatives lives.</p>

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA
Evidence: Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the relief manager and caregivers described how residents are informed about advocacy and support. A resident advocate (Chaplain) is available at Gladys Mary. Interviews with six rest home residents confirmed that they are aware of their right to access advocacy. D4.1d; Discussion with three family identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e,: Six resident files reviewed included information on resident’s family/whanau and chosen social networks.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

D3.1h; All relatives interviewed stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit.
There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with six rest home residents confirmed that the activity staff help them assess the community such as go shopping.
D3.1.e Discussion with four caregivers, and three relatives that they are supported and encouraged to remain involved in the community and external groups

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA
Evidence: <p>The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with six rest home residents and three relatives confirmed they were provided with information on complaints and complaints forms. 2013 complaints were reviewed and included three written complaints and two verbal complaints. All were well documented including investigation, follow up letter and resolution.</p>

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA
Evidence: <p>Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan.</p> <p>Gladys Mary set specific quality goals for 2013 including (but not limited to); a) Concentrated on improving the environment .b) to ensure that all caregivers have enrolled and completed the dementia units by 31 July 2013; c) to ensure the Gladys Mary staff become active and participate in the B-fit programme.</p> <p>Bupa Gladys Mary provides rest home, and dementia level care for up to 38 residents. There are 16 of 17 residents in the dementia unit and 20 of 21 residents in the rest home.</p> <p>The service has a house GP that visits weekly and a number of residents that have their own GP..</p> <p>The organisation has a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. Feedback from this committee is provided back to Gladys Mary in the form of newsletters.</p>

Gladys Mary has a newly appointed Facility Manager, registered nurse (RN). She has only been in the position for one week and is being orientated and supported into the role by the current Bupa relief manager (RN). The new manager has many years' experience in aged care including dementia care and management. The service is also currently advertising for a registered nurse in place of the Clinical Manager role. There are job descriptions for both positions that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. ARC,D17.3di (rest home), the manager have maintained at least eight hours annually of professional development activities related to managing a rest home.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA
Evidence: During a temporary absence, the Bupa relief manager covers the manager's role. The service is supported by the Bupa Operations Manager from the midland region. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA
Evidence: Gladys Mary has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms demonstrate a focus on quality improvements. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good

practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures cross-reference other policies and appropriate standards/reference documents.

Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted at Gladys Mary). A policy/procedure sign off sheet is completed by Gladys Mary staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the two monthly quality committee at Gladys Mary. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation.

There are monthly accident/incident benchmarking reports completed by the facility manager that break down the data collected across the rest home, dementia unit and staff incidents/accidents.

The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints.

There is a two monthly IC committee. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee.

Health and safety committee meets two monthly and is also an agenda item at the quality committee.

The service has established corrective action plans (CAP) where incidents/infections are above the benchmark; example: In October 2013, falls were high in the rest home and also in the dementia unit. A QI – corrective action plan established. Falls reduced in the rest home, but continued to remain above the benchmark in dementia unit in November.

Documentation reviewed and interviews identify that Gladys Mary continues to implement the Bupa quality and risk management process. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Benchmarking reports are generated throughout the year to review performance over a 12-month period. Feedback is provided to Gladys Mary via graphs and benchmarking reports. Overall their clinical indicators remain low, with skin tears being higher in the rest home for six months and falls remaining high at least five months in 2013.

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the Operations Managers region is also provided for the Operation Manager, which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year.

D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2013 with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury (these have continued from 2012). On-going review of these objectives for Gladys Mary is seen in H&S/quality meeting minutes.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: PA Low
Evidence: D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Category one incidents. The completed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Incident forms reviewed for January 2014 (to date) and December 13 identified shortfalls in documentation. D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark including (but not limited to); challenging behaviours in the rest home in December 2013. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: PA Moderate
Evidence: D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with an area to document immediate action and any follow up action required. Incident data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were sited for incidents above the benchmark including (but not limited to); challenging behaviours in the rest home in December 2013.
Finding: The following shortfalls were identified in incident forms reviewed; (i) two falls by a resident on the same day were completed on the same incident form. (ii) four incidents resulting in injury, identified a lack of documented assessment by the registered nurse on the incident form or progress notes (it was noted that the incident form identified by the writer that the RN was informed and completed an assessment); (iii) two incident forms identified the resident had hit their head, however there was no documented evidence of neuro obs completed as per policy.
Corrective Action: Ensure incident form documentation is fully completed including follow up assessment.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA

Evidence:

Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Five staff files reviewed (three caregivers, cook, and activity therapist) included up to date performance appraisals and documentation. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. Completed orientation booklets are on staff files. Staff interviewed (four caregivers, and activity therapist) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the operations manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures).

There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. A number of toolbox talks have been completed at Gladys Mary.

There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. dementia, delirium. Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education provided is an agenda item of the monthly quality meetings.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

20 Staff have current First Aid Certificates. Two new staff members are in the process of completing their foundation Skills. Two caregivers are attending the Walking in Another's Shoes education at the HBDHB and two have completed the course.

E4.5f There are 20 caregivers that work in the dementia unit. 16 have completed the required dementia standards, two are in the process, one (new staff member) is yet to process and one casual night caregiver is yet to start.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.

At night, there are two caregivers rostered in the rest home and one in the dementia unit.

The facility manager is also responsible for the clinical oversight. The service is advertising to recruit another RN

Interviews with two relatives from the dementia unit, one from the rest home and six rest home residents all confirmed that staffing numbers were good.

Caregivers interviewed stated that they have staffing levels were good.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA
Evidence: <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time.</p> <p>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard in both areas.</p> <p>Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing.</p> <p>Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p> <p>D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name.</p>

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA
Evidence: Gladys Mary rest home and dementia unit have a well-developed assessment process and residents' needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and/or relatives are provided with information in relation to the service. Information gathered at admission is retained in the residents' records. The six residents and three

family members interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents and families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the Health and Disability Code of Rights, how to access advocacy and the health practitioners code.

The service conducts an assessment on all new residents. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.

E4.1.b There is written information on the service philosophy and practices. Included in the information pack is dementia specific documentation for those entering the dementia unit. Information involves (but is not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Three resident files were reviewed in the dementia unit and all include a needs assessment as requiring specialist dementia care.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

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.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

There are records kept of reason for any declined entry; due to there being no beds available or else the unavailability of required level of care (for example the need for a hospital or psychogeriatric care). On interview management were able to discuss the process of declined entry and support and alternatives for those declined.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

There is an admission – role of caregiver policy, an admission – role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.

In six of six files sampled (three in the rest home and three in the dementia unit) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a RN. Medical assessments are completed on admission by the GP in six of six files sampled and six monthly multi-disciplinary reviews are completed by the RN with input from caregivers, the GP, the activities coordinator and any other relevant person.

Activity assessments and the activities sections care plans have been completed by an activities coordinator. Six residents interviewed (all from rest home) stated that they and their family were involved in planning their care plan on admission and again on evaluation. Resident files included family contact records which were completed and up to date in all six resident files sampled. D16.2, 3, 4: The six files reviewed (three in the rest home and three in the dementia unit), identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by a RN and amended when current health changes. All six care plans evidenced evaluations completed at least six monthly. D16.5e: All six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment.

Caregiving staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. All six files identified integration of allied health and a team approach is evident in the six files. There is no designated house doctor with several local GPs visiting the service. The GP interviewed spoke positively about the service and describes very effective communication processes. All six files have at least an initial physiotherapy assessment with on-going assessments as necessary.

Tracer methodology: rest home
 XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology: dementia unit
 XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: PA Low

Evidence:

The assessment booklets implemented at Gladys Mary provides very in-depth assessment tools to monitor: falls, pressure area risk, skin integrity, modified nutritional assessment (MNA), continence, pain, dependency and activities. The falls assessment section also includes additional risk factors, for example: vision, mobility, behaviours, environment and continence. These risk assessment tools and monitoring forms are reviewed at least six monthly and are used to effectively assess level of risk and required support.

The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information.

Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. The manager advised that continuing needs/risk assessments are carried out by the RN, however the auditor identified these are not always documented (link 1.3.6.1).

Six of six resident files sampled (three rest home and three dementia unit) contain assessments including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, skin assessment, MNA, incontinence assessment, behaviour assessment, and wound assessment (where appropriate).

One of three dementia resident files evidence falls risk assessment which is transferred to the resident's long term care plan. One of three dementia resident files evidence completed nutritional assessment MNA. Two of three dementia resident files have falls risk identified but not linked to long term care plans. Two of three dementia resident files have incomplete MNAs. The assessment booklet includes input from team members.

Notes by GP and allied health professionals are evident in residents files. Families interviewed [two in the dementia unit and one in the rest home] and the six residents in the rest home evidenced their involvement in the assessment process on admission and at routine care evaluations.

ARC E4.2; D16.2; All six resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: PA Low

Evidence:

Three of three dementia resident files evidence that falls risk is identified. One of three dementia resident files evidence that MNA is fully completed.

Finding:

Two of three dementia resident files have falls risk identified but not linked to long term care plans. Two of three dementia resident files have incomplete MNAs.

Corrective Action:

Ensure that identified falls risks are linked to long term care plans. Ensure that residents MNAs are accurately completed.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: FA

Evidence:

The sample of files reviewed included; three dementia resident files and three rest home resident files.

Service delivery plans overall demonstrate service integration (link 1.3.6.1) and demonstrate input from allied health professionals. All short term and long term care plans reviewed were completed by a RN.

Notes by GP and allied health professionals, significant events and communication with families.

The long-term care plan is completed within three weeks with GP involvement within 48 hours. Plans are well described and are reflected in the progress notes. Overall the six residents' care plans reviewed (three dementia and three rest home) provide evidence of individualised support and intervention required.

The six rest home residents interviewed and three families interviewed (one in the rest home and two in the dementia unit) confirm care delivery and support by staff is consistent with their expectations.

E4.3 Six resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; Resident files reviewed identified that family were involved.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: PA Low
Evidence: <p>Residents' care plans are completed by the RN. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes reviewed). When a resident's condition alters, the RN initiates a review and if required, GP or specialist consultation. However, this is not always documented. There is a documented evaluation in one dementia unit file of change to nutritional needs. This has not been transferred to the relevant section of his long term care plan.</p> <p>The four caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Six rest home residents interviewed and three families interviewed (two in the dementia unit and one in the rest home) were complimentary of care received at the facility.</p> <p>Overall the long term care plans reviewed were up to date (link 1.3.6.1). The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers, three families interviewed, and facility manager. There is a short-term care plan that is used for acute or short-term changes in health status.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Specialist continence advice is available as needed and this could be described.</p> <p>Continence and wound management in service education have been provided in October 2013 (continence training) and in April 2013 (wound care).</p> <p>Wound assessment and wound management plans are in place for seven residents.(six with minor skin tears and one with an infected ingrown toenail).</p>

There are no pressure areas identified in the service. All wound assessments have completed short term care plans describing appropriate interventions. The RNs (facility manager and relief manager) interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: PA Low

Evidence:

All six resident files reviewed have evidence of timely assessments and subsequent care planning. Residents' lifestyle care plans are completed by the RN in both the rest home and dementia unit. Caregivers routinely document support/care given in the residents' progress notes (every shift). Six residents and three relatives interviewed voiced satisfaction for the care received at Gladys Mary Home.

Finding:

The following shortfalls were identified; a) three three rest home resident files reviewed had no documented RN follow-up in progress notes following changes to health status or following a fall; b) One dementia unit resident's care plan evaluation recognised a change to his nutritional needs (recent choking incident and change to thickened fluids and soft diet). This was not reflected in the relevant section of his long term care plan.

Corrective Action:

a) Ensure that RNs document in the resident progress notes all assessments, and observations and follow up interventions, b) Ensure that identified changes at time of care plan evaluations are reflected in changes to relevant sections of the long term care plans.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA

Evidence:

There is one activity coordinator who works in both the rest home and dementia unit for six hours per day Monday to Friday. She has held this position for five years and has a Diploma in Early Childhood Education and has also completed the Dementia Unit Standards. She is enrolled to start the diversional therapy training through Careerforce this year and attends local meetings with other activities personnel from other facilities. She also completes self directed learning through use of relevant websites and in particular the Bupa website.

On the day of audit residents in both areas were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print in communal areas and resident bedrooms. Six of six residents and three of three families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met.

Residents have an activities assessment completed over the first few weeks after admission obtaining a complete history of past and present interests,

career, family etc. On interview the activities coordinator was able to evidence her involvement in care planning meetings with others in the health care team and relevant family members and/or residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review and is evaluated.

The programme includes (but not limited to); networking within the community with social clubs, schools etc. On or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident activities. There are recreational progress notes in the resident's file that the activity officer completes for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. Three family members interviewed stated they had input into these plans on admission and at evaluations. There is a wide range of activities offered that reflect the resident needs in the rest home and dementia unit with participation being voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.

Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit which are conducted by care staff out of normal hours. Gladys Mary has a facility van which is used for regular outings. (two times a week for the rest home and once a week for the dementia unit).

Spiritual needs are recognised in the programme with three different local churches routinely visiting. Resident meetings are scheduled onto the programme every two months.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA
Evidence:
Care plans are reviewed and evaluated by the RN at least six monthly or when changes to care occur as sighted in five of six care plans sampled. (One

dementia unit resident is new to the service). On interview the activities coordinator was able to discuss her part in care planning evaluations. There is also documentation evidence of family and/or resident involvement at these evaluations. On interview, three relatives confirmed that they were invited to attend care-planning review meetings.

Documentation on clinical notes evidence review by the GP at least three monthly.

There are short term care plans to focus on acute and short-term issues. Changes to the long-term care plan (link 1.3.6.1) are made as required and at the six monthly review if required. From the sample group of residents' notes the short-term care plans are generally well used and comprehensive.

Examples of short-term plan use included; infections, wounds and unexplained weight loss.

D16.4a Care plans are evaluated six monthly and more frequently when clinically indicated.

ARC: D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, physiotherapist, podiatrist, mental health services and hospital specialists. Caregiving staff were able to give examples of residents having specialist services provided. D16.4c; The service provided an example of where a resident's condition had changed there was reassessment for a higher level of care. D 20.1 Discussions with the relief and facility manager identified that the service has access to specialist nursing services such as continence nurses, palliative care services and wound specialist nurses.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is a transfer plan policy. A record is kept and a copy is kept on the resident's file. This was sighted in one resident file (from the dementia unit) where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to the receiving facilities. Follow up occurs to check that the resident is settled in hospital, or in the case of death, communication with the family is made. Both caregiving staff and the nurse manager were able to discuss the process of transfer.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: PA Moderate

Evidence:

The medications are stored in locked trolleys for each of the two areas (dementia unit and rest home). Controlled drugs (CDs) are stored in a locked safe in the treatment room. (nil residents on CDs at the time of audit). The registered nurse (RN) has access to controlled drugs and two people must sign the medicine out. The facility manager or senior caregivers assessed as medication competent, administer medications. In service education and medication competency was last held in April 2013 and is scheduled annually alongside competency renewal.

The service uses two weekly robotic packs. Medication charts have photo identification. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and reported back to the supplying pharmacy. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and up to date competencies. Medication systems are monitored routinely (six monthly) and the last internal audit of medicine management was held in August 2013. At present there is no resident self-administering medications. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. Signing sheets correspond to instructions on the medication chart. The controlled drug register is well kept and aligns with legislative requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the GP at least three monthly. Charts are easy to read and current. When prescribing prn medications GPs to the service have charted prn medications clearly and safely. D16.5.e.i.2; All of the 18 medication charts reviewed had been reviewed by the GP at least three monthly and medication charts signed. There is an improvement required to medication documentation.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: PA Moderate

Evidence:

Policies and procedures guide staff in the safe management of medicines. Medicine management is monitored six monthly as part of the internal quality programme. Prn medication prescribing in 13 out of 18 resident medication charts have documented guidelines for use. Seventeen of 18 signing sheets evidenced 17 out of 18 were fully completed. On review of non-packaged medications in medication trolleys, storage and medicine reconciliation is appropriate. Medicine requiring refrigeration is evident and fridge temperatures monitored and recorded appropriately.

Finding:

a) Five out of 18 medication charts do not have sufficient guidelines for use of prn medication (four in the dementia unit and one in the rest home), b) On review of non-packaged medications stored in medication trolleys, two eye drops were not disposed of after one month of use (dementia unit); c) One signing sheet for non-packaged medication administration had two entries for the same medication for over one month.

Corrective Action:

Ensure that all prescribed prn medications have guidelines for maximum dose and frequency of use. Ensure that medicine management involves routine checks of non-packaged medicines to check for expiry dates and medications requiring disposal. Ensure that there is one signing sheet per medication.

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

The national menus have been audited and approved by an external dietitian. The service employs four kitchen staff including two cooks. The rest home kitchen provides meals for the dementia unit which is transported to the unit in a bain marie trolley. All of the kitchen staff have completed food safety certificates. The service has a large workable kitchen that contains one walk-in pantry, freezer, Domestic fridge containing snacks for residents in the dementia unit, a walk-in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area. Kitchen fridge, food, bain marie, dishwasher and freezer temperatures are monitored and documented daily. Resident annual satisfaction survey includes food services and there is also a post admission survey conducted after six weeks. There are a number of internal audits completed including; a) weight monitoring (August 2013) and b) Environmental hygiene - kitchen (August 2013).

There is a nutrition - assessment and management policy and a weight management policy.

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, high calorie meals, vegetarian, pureed meals and diabetic diets. In service education on hydration and nutrition was held in August 2013.

There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety. Hats and gloves are worn routinely in the kitchen.

Bupa Care Homes introduced in 2010 a comprehensive food services programme that specifically targeted all areas of the food service as a quality improvement initiative throughout the business. This was in response to further improving on client satisfaction results with the service as identified through resident/relative satisfaction surveys. Achievements of the programme which continues in 2012 include the introduction of a Steering group, monthly teleconferences with the chefs/cooks employed in each home, development of Bupa's own Recipes and Library of these and the review and update of all kitchen policies and procedures. Other activities included the development of "assisted eating posters" which a "Masterchef" DVD with Annabelle White, a dementia specific focus included emphasis on use of coloured crockery and suitable tasty finger foods and a streamline national food contract supply for meat, groceries and vegetables. The programme also developed food safety training powerpoints to augment the internal core education programme within care homes. A senior chef within the business provides support and mentorship to the cooks in each of the homes and following the pilot of a training programme for staff, Bupa kitchen staff complete unit standard 167 Food safety training. "Showing we care on a plate" was the title/catch phrase for the programme. This was described by the cook on interview.

Rest home residents interviewed stated they were happy with the food service. Three out of three relatives also were complimentary of the food provided. Observation of meal time (lunch) evidenced staff assisting residents as required.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours. (Designated fridge).

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

Chemical/substance safety policy (048) at Gladys Mary guides all staff in the management of all waste and hazardous substances. There are policies on the following:- waste disposal policy which covers the disposal of medical waste, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics. There is a procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff and an education conducted in January and April 2013 around chemical safety.

All chemicals are clearly labelled with manufacturers labels. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated on interview a clear understanding of processes and protocols.

Gloves, aprons, and goggles are available for staff and are evident in all areas of the facility. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA
Evidence: <p>There is a maintenance person who works a total of 20 hours per week and on call. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on Novemebr 2014. Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas are well maintained and gardens are attractive. There is garden furniture and plenty of shade. There is wheelchair access to all areas. The gardens have all been upgraded since previous audit including (but not limied to) new fencing, paving and gardens. The outside areas are attractive and inviting and all six residents and three relatives were complimentary regarding the outside areas. There are water features and raised vegetable</p>

gardens and residents are encouraged outside when the weather allows.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3: The following equipment is available: pressure relieving mattresses, shower chairs, two hoists, heel protectors and mobility/handling aids.

Interviews with four caregivers from the rest home and dementia unit confirmed there was adequate equipment.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c: There is a safe and secure outside area that is easy to access off the dementia unit. The outside area for residents in the dementia unit is well designed and appropriate for residents who like to walk about.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: The rest home and dementia units evidenced sufficient toilets and showers for the resident population. There is also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and shower curtains installed. Paper hand towel dispensers and flowing soap are available for use in all toilet areas. All six residents in the rest home interviewed reported that their privacy is maintained at all times.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

The rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Four caregivers from across each area report that rooms have sufficient room to allow cares to take place. Six of six residents interviewed voiced their satisfaction for the size of their bedrooms.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a large lounge and large separate dining rooms in both the dementia unit and rest home. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and six residents interviewed report they can move around the facility and staff assist them if required.

ARC E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed six monthly (last one July 2013). An environmental hygiene - cleaning audit was last completed in June 2013 and scored 100%. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly

labelled. Chemicals are stored in a locked room . All chemicals are labelled with manufacturer's labels. There is sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Six from six residents interviewed confirmed that the facility was kept clean.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety was last held in February 2013. Fire evacuations are held six monthly. A fire evacuation was last held in August 2013. There is staff across 24/7 with a current first aid cert. There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard; this includes an up to date register of all residents details. There is an approved evacuation plan. The facility is well prepared for civil emergencies and has emergency lighting and BBQ's. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits. Hoists have battery back and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas and indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were overall answered in a timely manner. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

The facility has overhead/ceiling heating, heat pumps and wall mounted heaters which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored monthly.
All six residents and three relatives interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in residents rooms.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint policy (251) states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however, we acknowledge that there may be occasions when a resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated. There is a Regional Restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy.

The service remains restraint and enabler free.

There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level. Training and competencies have been completed by staff.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

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.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: <p>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The infection control committee includes a cross section of staff all areas of the service.</p> <p>The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the G.P's, local Laboratory, the infection control and public health departments at the local DHB. There are two monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the staff meetings. Minutes are available for staff.</p> <p>Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. There is a staff health policy.</p> <p>There has been no outbreaks.</p>

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the facility manager, (IC coordinator), and other staff. The facility also has access to an infection control nurse specialist, public health, G.P's and expertise within the organisation.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

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.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA
Evidence: D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases. Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator, the infection control committee and expertise from the governing body

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator (facility manager) has recently taken over the role and has completed training through Bug control previously. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was last provided November 2014 (five attended). Toolbox talks have been provided around (but not limited to); minimising UTIs, and oral care Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around IFC discussed at resident/relative meeting

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>