# Bupa Care Services NZ Limited - NorthHaven Hospital

## Current Status: 30 January 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance 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

Northhaven hospital is part of the Bupa group of facilities and provides care for up to 106 geriatric -hospital/medical, psychogeriatric, rest home and physical disability care. On the day of the audit there were 98 residents (75 hospital residents, three resthome and 20 psychogeriatric residents).

Northhaven has continued to implement a comprehensive quality and risk management system since the previous audit. The service is managed by an experienced aged care manager and clinical manager (both experienced registered nurses). The facility manager has been appointed to her new role in August 2013 and she was previously managing another Bupa facility. There are also three unit coordinators (RN) across each area. The management team is supported by the Bupa operations manager.

The service has addressed two of the three shortfalls identified at the previous audit around medication management and wound documentation. An improvement continues to be required around care plan interventions.

This unannounced surveillance audit identified improvements required around aspects of clinical documentation, environmental restraint and dementia training.

## Audit Summary as at 30 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 |
|  | 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 30 January 2014

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

### Organisational Management as at 30 January 2014

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| 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. |

### Continuum of Service Delivery as at 30 January 2014

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

### Safe and Appropriate Environment as at 30 January 2014

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

### Restraint Minimisation and Safe Practice as at 30 January 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Infection Prevention and Control as at 30 January 2014

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

# 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**

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| --- | --- |
| **Legal entity name:** | Bupa Care Services NZ Limited |
| **Certificate name:** | Bupa Care Services NZ Limited - NorthHaven Hospital |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Northhaven Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (incl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical | | | |
| **Dates of audit:** | **Start date:** | 30 January 2014 | **End date:** | 31 January 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 98 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 14 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 28 | **Total hours off site** | 5 |
| **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**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 42 | Total audit hours off site | 13 | Total audit hours | 55 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 13 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 5 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 108 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 4 |  |  | 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:

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| --- | --- | --- |
| 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 | Yes |
| 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 Tuesday, 11 March 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Northhaven hospital is part of the Bupa group of facilities and provides care for up to 106 geriatric -hospital/medical, psychogeriatric, rest home and physical disability care. On the day of the audit there were 98 residents (75 hospital residents, three resthome and 20 psychogeriatric residents).  Northhaven has continued to implement a comprehensive quality and risk management system since the previous audit. The service is managed by an experienced aged care manager and clinical manager (both experienced registered nurses). The facility manager has been appointed to her new role in August 2013 and she was previously managing another Bupa facility. There are also three unit coordinators (RN) across each area. The management team is supported by the Bupa operations manager. The service has addressed two of the three shortfalls identified at the previous audit around medication management and wound documentation. An improvement continues to be required around care plan interventions.  This unannounced surveillance audit identified improvements required around aspects of clinical documentation, environmental restraint and dementia training. |

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| **Outcome 1.1: Consumer Rights** |
| A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Incident forms reviewed showed that open disclosure principles are implemented. As part of the internal auditing system, incident/accident forms are audited twice a year ensuring that family notification occurs. The audit outcomes are communicated to staff and corrective actions are implemented. The complaints process meets the requirements of the Health and Disability Consumers Code of Rights. There is a complaints register that is up to date that includes written and verbal complaints and response letters, investigation and follow up resolution letters. There is evidence that several quality improvement projects are implemented following a complaint. |

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| **Outcome 1.2: Organisational Management** |
| Northhaven 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 the monthly quality committee. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the psychogeriatric, hospital units and staff incidents/accidents. Health and safety committee meets monthly and is also an agenda item at the quality committee.  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. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to staff via graphs and benchmarking reports.  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 operations managers, which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators throughout the year.  Work place inspections are completed by Bupa for each facility to show compliance in all areas. Following this audit, Northhaven completed a follow up audit after the inspection in April 2013.  Quality improvement alerts are also part of the quality improvement process. Following an incident or an external audit outcome of any Bupa facility is communicated to all the facility by issuing alerts/memo.  Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Northhaven and documented actions have improved outcomes or efficiencies in the facility. There is a comprehensive health and safety and risk management programme in place. Hazard identification, assessment and management policy guides practice. Human resource policies are implemented and all staff files reviewed had completed performance appraisals, orientation documentation and staff training records and recruitment process records. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Audit identified a shortfall that not all caregivers working in the PG unit have completed dementia standards. The organisational staffing policy aligns with contractual requirements and includes skill mixes. The Bupa wage analysis schedule (WAS) is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. Residents and relatives interviewed confirm safe staffing level and skill mixes. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, the short-term care plans, and the long-term support plan to guide staff in the safe delivery of care to residents. The care plans are goal oriented and reviewed every six months with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is an improvement in wound management and medicine management from the previous audit. Improvements are required around the documentation of interventions, pain assessments and behaviour monitoring. The previous audit shortfall related to care plans reflecting current needs remains an area requiring improvement. There are separate activity programmes for the rest home/hospital units and psychogeriatric unit that meets the individual needs, preferences and abilities of the residents.  Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency test and receive annual education.  Residents' food preferences are identified at admission. This includes consideration of any particular dietary preferences or needs (including cultural needs). Likes and dislikes are kept in the kitchen. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has a current Building Warrant of Fitness. Fire drills are attended six monthly. There is a 52-week maintenance programme in place. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The restraint policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Enablers are assessed as required for maintaining safety and independence. Enablers are used voluntarily. Monitoring of enabler and restraint use (bed rails) are monitored. Training has been provided around restraint, enablers and challenging behaviours. The audit identified use of environmental restraint in the hospital/rest home wing. Improvements are required around reviewing the environmental restraint, resident re-assessment and interventions to manage the impact of environmental restraint. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control (IC) surveillance programme is appropriate to the size and complexity of the facility. Effective monitoring of IC is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and training. Surveillance data is available to all staff and staff interview confirmed understanding of the value of surveillance. There is an infection control register that includes all infections and are documented monthly. Review of meeting minutes showed discussions around infection control issues and alerts for staff. The IC programme is linked with the quality management programme and quality Improvement initiatives are taken and recorded as part of continuous improvement. Northhaven had completed several quality improvement projects around IC since the previous audit. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 1 | 3 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 3 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 59 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | ARHSS D17.1: Interview with staff and staff training record shows that the Northhaven employs 44 caregivers who works in the PG unit and 11 of those staff who is employed over a year have not completed required dementia care standards. | Ensure that staff who work in the PG unit have completed dementia training within a year of employment. | 180 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Gaps in documentation of interventions in care plans are identified in two of two psychogeriatric care plans sampled, four of four hospital resident care plans sampled and one of one rest home care plan sampled.  Gaps identified in hospital resident files are (i) specific or alternative strategies are not included in the care plan to support freedom of movement such as walks outside or in the garden area. There has not been a review of the resident’s mobility status in regards to environmental restraint (link 2.1.1.4). The same resident does not have a documented clinical management plan for seizures, ii) no documented pain management identified in the care plan, and iii) there are no documented interventions for resident with weight loss, iv) resident with sacral pressure area does not have any pressure area management documented in the care plan.   The one rest home resident file sampled does not have a clinical management plan in place for a recent episode of melena (Oct 13).  Gaps identified in the two psychogeriatric resident files sampled are; i) the care plan does not document in the care plan the change in level of supervision required and ii) there is no MRSA alert or infection control management documented in the care plan. | Ensure all identified needs have interventions identified and described in the care plan. | 60 |
| 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 Moderate |  |  |  |
| 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 Moderate | i) There is no pain assessment or the monitoring of pain for one hospital resident with a new episode of pain (as per GP notes). ii) There is no behaviour management plan or behaviour monitoring chart in place for one hospital resident with altered behaviours. iii) One rest home resident seen by the GP for an episode of aggressive behaviour does not have behaviour monitoring in place as requested by the GP (link 1.3.3). iii) One hospital resident known to have recent hypoglycaemic episodes (as per progress notes/medical notes) had not had daily sugar monitoring for seven consecutive days. | i) Ensure pain assessments and monitoring is completed for new episodes of pain. ii) Ensure behaviour monitoring and behaviour management plans are in place for residents with altered behaviours. iii) Ensure blood sugar monitoring frequency is carried out as instructed. | 60 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Moderate |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Moderate | There is a keypad lock at the front door of the hospital and the code is not in sight. Therefore, residents and visitors cannot independently enter and exit the facility. A secure outdoor area in the hospital wing (second floor) has a keypad lock to exit to the courtyard that also has high fences. There is also a keypad entrance back into the facility from the courtyard. This restricts residents to use the outdoor area freely and potentially can lead a resident trapped in the outdoor area.  Advised that all residents, relatives and visitors must ask for codes to exit doors. As the units are secure, it makes it an environmental restraint for all residents. While Bupa have included environmental restraint in the restraint policy included management strategies. The service has only included two residents on the restraint register as environmental restraint. Those two residents do not have NASC re- assessment indicating they needed a safe environment and as their mobility has improved since their care plan lacks instructions for minimising the impact of environmental restraint. | Ensure that restraint minimisation policy around environmental restraint is fully implemented. Review the current environmental restraint. Ensure the two residents impacted by environmental restraint are reassessed | 30 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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 1.1.9: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff of 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 three unit coordinators (one PG and two hospital), two registered nurses (hospital) interviewed stated that they record contact with family/whanau on the family/whanau contact record (sited). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for November and December (seven hospital, and 10 PG unit) all identified that family were notified. As part of the internal auditing system, incident/accident forms are audited ensuring that family notification occurs. This is completed two times a year. The audit outcomes are communicated to staff and corrective actions are implemented.  D16.4b:The five relatives interviewed (five hospital) stated that they are always informed when their family members health status changes.   The Bupa communications manager keeps people informed and engaged about Bupa NZ’s strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed. Newsletters are evident at the main reception.  Interpreter’s policy and a list of Language Lines and Government Agencies are available. In addition, there is a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available.   D12.1: Non-Subsidised residents/EPOA 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 'D11.3 The information pack is available in large print and advised that this can be read to residents.  ARHSS: D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to the secure unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident’s handbook providing practical information for residents and their families. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a complaints register that is up to date that includes written and verbal complaints and response letters, investigation and follow up resolution letters. (11 complaints in Jan- Dec 2013). Two of the complaints are currently under investigation by the management team and review of these complaints shows timely response to the complainants and are in line with Code 10 of the H&D Code of Rights.  One of the complaints is reviewed as part of the audit process. The complaint was related to the food services. Following this complaint, delivery of food services, content and variety of the menu were reviewed. Northhaven purchased a heated meal trolley (scan box) which is being used at the hospital, which is located on the second floor of the building. The purpose of this is to provide meals at the right temperature. The complaint is discussed with the cook who is fully aware of the complaint and explained the improvements initiated. These include, vegetables are steamed and timing of cooking is adjusted and a slow cooking method is used for the cooking of meats. The variety of sandwiches and soups are improved. Alternatives and special menus are sighted in the kitchen, which identifies resident’s likes and dislikes. Residents (one rest home and three hospital)) and families (five hospital) interviewed stated satisfaction with the meal service. Four caregivers and three unit coordinators interviewed confirmed that these changes in food service have been implemented.  The complaints policy and process is included in the residents' information booklet and the complaint forms are displayed in the main foyer. Complaints are included in the weekly and monthly reports to the Bupa head office as part of the quality indicators. The five relatives (hospital) and four residents (two rest home and two hospital) interviewed stated that they are comfortable in discussing any concerns with the facility manager and the unit managers. If there are any issues these are addressed in a timely manner. Concerns or complaints identified from the minutes of quality meetings and staff meetings and have corrective action plans implemented. The four caregivers interviewed are aware of the complaints process and their responsibilities in reporting complaints. |

##### **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.

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

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

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

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| **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 1.2: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| 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. On the day of the audit, as part of the quality meeting Northhaven staff set specific quality goals for 2014. The facility manager advised that progress to meeting those goals will be reported monthly. Review of the 2013 meeting minutes evidenced regular reporting on 2013 goals which includes (but is not limited to); a) develop and support the team as leaders in care, b) deliver person centred care by ensuring residents have more choice in their life at Northhaven, c) make Northhaven a safe homely place by reducing falls by 10%, d) improve communal areas, e) achieve 90% customer satisfaction and f) have 70% of care staff working or completed the dementia care standards. The annual quality goals report shows achievement in all quality goals except customer satisfaction, which was around 84% in 2013.   Northhaven provides hospital - medical/geriatric, intellectual and physical, rest home, and psychogeriatric care for up to 106 residents. The occupancy on the day of the audit was 98 residents. There are three rest home residents, 75 hospital residents across the four hospital units and 20 residents in the 20-bed secure psychogeriatric (PG) unit. There are four residents under an YPD contract and one of these resident’s is under an intellectual disability contract. There is one resident under respite care (hospital).  Bupa has robust quality and risk management systems implemented across its facilities. Northhaven uses benchmarking in hospital and psychogeriatric care. Bupa has a Clinical Governance group and the committee meets two monthly. The committee reviews the past and look forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee meet two monthly. Feedback is provided to each facility (sighted at Northhaven).  The facility manager (RN) has been appointed to the role August 2013 and she was previously managing another Bupa facility. She is an overseas-trained RN with experience in medical surgical nursing and prior to her transfer to NZ, she was managing a Bupa service in England. The facility manager is supported by a clinical manager who commenced the role November 2013. There are also three unit coordinator positions across each area.  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. The clinical manager’s personal file is reviewed and included a completed orientation. The facility manager reports to the operations manager who is newly appointed to her role.  ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.   ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Northhaven continues to have an implemented quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements and this continues to be maintained since the previous audit. Quality and risk performance is reported across the facility meetings, through the communication book, staff noticeboard 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. A Bupa 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 would also be decided. These group members are asked to provide feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the Quality and Risk Team. Finalised versions include appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents.   Key components of the quality management system link to the monthly quality committee. Weekly reports by the facility manager to the Bupa operations manager and quality indicator reports to the Bupa quality coordinator provide a coordinated process between service level and organisation.   There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the psychogeriatric, hospital units 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 monthly IC committee meeting. 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 monthly and is also an agenda item at the quality committee. Health and safety and incident/accidents internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation.   Monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. 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. Feedback is provided to staff via graphs and benchmarking reports. Northhaven is benchmarked in two areas with other Bupa facilities (psychogeriatric and hospital).  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 operations manager shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year.  Facility Health checks (organisational internal audits) are completed by the Bupa for each facility to show compliance in all areas. Improvements were noted between the two audits (compliance improved from 65% to 86%). Following the most recent facility health check, Northhaven implemented a new PRN medication-signing sheet to improve compliance around medication documentation (Walls and Roche-Bupa medication chart).  Quality improvement alerts are also part of quality improvement process. Following an incident or an external audit outcome of any Bupa facility is communicated to all the facility by issuing alerts/memo. These were sighted as actioned at Northhaven.   Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Northhaven and document actions that have improved outcomes or efficiencies in the facility i.e. a new meal delivery trolley to keep residents food hot, review of meal services following a complaint and use of cranberry capsules for UTI reduction.   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; Northhaven reports 89% achievement. Second objective is to reduce number of staff injuries by resident’s behaviour by 10%. This objective has not been achieved yet. November 2013 report indicates that Northhaven continue to strive on this goal by increasing training and support to staff. Health and safety meeting minute’s shows that health and safety plan 2014 goals are discussed with the staff and staff encourage developing and investing in the site-specific goals.  D19.2g Falls prevention strategies are in place that include 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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3c: Northhaven collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat 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)". D19.3b; Northhaven 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. Minutes of the quality meetings, staff and H&S meeting reflect a discussion of results.  Incident and accidents documentation audit was completed in November 2013 and shows 86.3% compliance. The audit includes the correct completion of the form, recording at the resident’s notes, minutes for follow up comments and corrective actions. Following this audit, corrective actions are completed and signed off by the facility manager.  Seventeen incident forms reviewed for November and December 2013 (seven hospital and 10 PG unit,) demonstrated that full description of the incident, detailed follow up and corrective actions. Incidents reviewed includes, falls with and without injury, skin tears, and bruising and medication errors. Two incidents in December required corrective action and these are completed and signed off. One incident in December resulted in head injury. Document review showed that the resident was monitored closely and required nursing assessments including neurological observations are completed. Required corrective actions are completed by the clinical manager.  A discussion with the facility manager 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Ten files reviewed (registered nurse, enrolled nurse, clinical manager, unit coordinator, six caregivers) all had up to date performance appraisals, validation of the individual’s qualifications and experience - copies of appropriate visa's and NZ qualifications. All staff files included a personal file checklist.  Register of RN and EN practising certificates is maintained.  Northhaven has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation booklets are on staff files. Staff interviewed (four caregivers, three unit coordinators) described the orientation process and stated that they believed new staff were adequately orientated to the service.  There is an annual education schedule that is being implemented. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. Dementia, Delirium. There is evidence on RN staff file of attendance at the RN training day/s and external training. For example, fall prevention, NikiT syringe driver training, IC training.   Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings. Toolbox talks held and staff been encouraged to participate.  A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires were sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training. Competency register is displayed on the notice board in the staff room area where staff are encouraged to take responsibility in maintaining up to- date competencies.  The Bupa "personal best" initiative which encourages staff to enhance the lives of the residents has been implemented at Northhaven. Personal Best – 73.7% caregivers have attained bronze certificate. 33.1% caregivers have attained silver certificate and 27.1% have completed gold.  There are 16 staff members with a current first aid certificate.  D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver. An improvement required around completion of dementia specific training within required timeframe. |

##### **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.

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

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Northhaven employs 108 staff and 15 of those staff are RNs. Interviews with the facility manager, clinical manager and caregiving staff confirm that staff turnover is low.  ARHSS D17.7: The activities coordinator and the activities assistant working in the PG unit have completed dementia training. |
| **Finding:** |
| ARHSS D17.1: Interview with staff and staff training record shows that the Northhaven employs 44 caregivers who works in the PG unit and 11 of those staff who is employed over a year have not completed required dementia care standards. |
| **Corrective Action:** |
| Ensure that staff who work in the PG unit have completed dementia training within a year of employment. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **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 the head office that includes staffing hours. The roster is managed according to the occupancy level and operations manager’s meeting minutes dated 12/11/13 shows 69 hours over staffing.  Since the previous audit, some changes have been made in the roster template and now, rather than a staff roster for each unit, two units run together with the exception of Weiti unit remains unchanged. Staffing is as follows:  Monday-Friday: facility manager and clinical manager.  Hospital Arkles unit (22 beds) and PG unit Shakespare (20 beds) AM Unit Co-ordinator 06.45-15.15- (5 days a week). 2x RN 06.45-15.15( 7 days a week 1x caregiver 07.45- 16.00; 4x caregivers 07.00 -15.15; 3x caregiver 07.00-13.00  PM 2xRNs 15.00-23.00 4xCaregiver 15.00-23.00 1xCaregiver 16.30-20.30  Waiwera and Matakatia- Hospital 20+20 bed capacity.  Unit coordinator- 06.45-15.15- (5 days a week). 2x RNs 06.45-15.15( 7 days a week) 4x caregivers 07.00 -1515; 1x caregiver 07.00-13.00 and 2x caregivers 7.00-12.30  PM 2xRN .15.00-23.00 2xCaregiver 15.00-23.00 2x Caregivers 16.00-20.30  Weiti – Hospital 24 bed capacity  Unit coordinator- 06.45-15.15- (4days a week Tues – Friday and works as the RN on the floor  1x RN 06.45-15.15 ( 3 days a week Mon-Sat and Sun) 3x caregiver 07.00 -1515; and 1x 7.00-12.30 ( 7 days a week) PM 1xRN .15.00-23.00 1xCaregiver 15.00-23.00 and 1x caregiver 15.15 -20.30 and 1 x 16.00 - 2300  Night across to the facility 2xRN -23.00-07.00 4xcaregiver-23.00-07.00 In the PG unit, there is a registered nurse across 24/7. Four caregivers interviewed across the two areas reported that staffing was good. Family (five) and residents ( four) interview also confirm sufficient staffing. |

##### **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.

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

## **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 1.3.3: 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; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D.16.2, 3, 4: The seven resident files sampled (one rest home, four hospital and two psychogeriatric) identified that the registered nurses (RN) complete an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All seven files sampled identified that the long-term support plan is developed within three weeks. All seven long-term care plans sampled are signed and dated by the RN. Families (five hospital) confirmed on interview they are invited to attend the six monthly multidisciplinary care plan reviews and GP visits. The diversional therapist (DT) completes an activity assessment, “Map if Life” and individual activity care plan in consultation with the resident/family/whanau as appropriate. There is documented evidence (signature) of resident/family/whanau involvement in the care plan process.  D16.5e: Five of seven resident files sampled identified that the GP had seen the resident within two working days. Two residents had been seen by the physician prior to being discharged to the facility. It was noted in all resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. All seven resident files sampled identified integration of allied health professionals and a team approach. There are three GPs in the practice that provides a daily medical service. The GP (interviewed) states the GP’s cover for each other patients and attend to residents of concern as required. The GP’s are available to meet with families. The GP is complimentary of the care provided to the residents such as wound care and commented that residents conditions often improve on discharge from hospital. The unit coordinators and staff manage the transition for residents very well. The medical service aim to reduce the use of psychotropic medications (in consultation with the psychogeriatrician) by 10% annually. The GP’s are available on mobile at the weekends.   ARHSS D16.6; Two residents files sampled with behaviours that challenge were reviewed from the psychogeriatric unit. Behaviours in the two files are well identified through the assessment process. Specific needs and interventions (including activities) are detailed in the long-term care plan. Behaviour monitoring charts are in use (sighted). The community mental health nurse is readily available and visits regularly to follow up residents that are being monitored under the mental health service. A dementia clinic is held weekly with the mental health nurse, unit coordinators and GP (if required). The mental health nurse liaises closely with the psychogeriatric team and GP. The mental health services for the older adult respond promptly to urgent concerns.  There is a verbal handover and written handover sheets at the beginning of each shift between the RN’s on duty. The RN then provides a report on all residents to the caregiving team. There is a duty leader on each shift. Four caregivers interviewed state the communication system is good and they receive relevant information at handover to deliver safe and timely cares for the residents. A physiotherapist is contracted for 10 hours a week. The physio is supported by two physio assistants who work 30 hours week (combined) and carry out physio instructions and exercise programmes for the residents. There is a dedicated physio room set up with the required equipment. The physio completes a transfer and mobility assessment on all new admissions. A physio diary is maintained and RNs enter referrals into the diary. The physio also records interventions, which is then transferred to care plans by the RN. The physio attends the six monthly MDT reviews and review residents post falls as required.  The consultant pharmacist from the district health board (DHB) reviews the medications for all new admissions. The gerontology nurse regularly visits and follows up on new admissions, provides advice and education as required.   Tracer methodology; Rest home resident XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology; Hospital level resident. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology; Psychogeriatric resident. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology; YPD.  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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous partial achievement remains around the documentation of residents identified needs in the care plan. |

##### **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Seven care plans sampled (four hospital, one rest home and two psychogeriatric) evidence multidisciplinary six monthly reviews. |
| **Finding:** |
| Gaps in documentation of interventions in care plans are identified in two of two psychogeriatric care plans sampled, four of four hospital resident care plans sampled and one of one rest home care plan sampled.  Gaps identified in hospital resident files are (i) specific or alternative strategies are not included in the care plan to support freedom of movement such as walks outside or in the garden area. There has not been a review of the resident’s mobility status in regards to environmental restraint (link 2.1.1.4). The same resident does not have a documented clinical management plan for seizures, ii) no documented pain management identified in the care plan, and iii) there are no documented interventions for resident with weight loss, iv) resident with sacral pressure area does not have any pressure area management documented in the care plan.  The one rest home resident file sampled does not have a clinical management plan in place for a recent health issue.  Gaps identified in the two psychogeriatric resident files sampled are; i) the care plan does not document in the care plan the change in level of supervision required and ii) there is no MRSA alert or infection control management documented in the care plan. |
| **Corrective Action:** |
| Ensure all identified needs have interventions identified and described in the care plan. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Residents' care plans are completed by the registered nurses. There is a short-term care plan that is used for acute or short-term changes in health status. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Long term care plans are goal oriented and reviewed six monthly in the hospital, rest home and psychogeriatric unit. Risk tool assessments are completed on admission and include (but not limited to); nutritional assessment, continence assessment, falls risk, physio mobility and transfer assessment, Iowa pain assessment, pressure area risk, hygiene and skin assessment and cultural assessment.  Four caregivers and three unit co-ordinators state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); ultra-low beds, perimeter mattress, sensor mats, pressure area mattresses, hoists (checked April 2013), chair scales (calibrated April 2013), slidy sheets, transferring belts, walking frames, wheelchairs, gloves, masks and aprons. Relatives interviewed confirm their relative’s needs are being met.   D18.3 and 4 -Adequate dressing supplies are available. Wound management policies and procedures are in place. A pressure area identification guide is available. Wound assessment and wound management plans are in place for three resident with sacral/buttock pressure areas in the hospital units. Interventions include the use of pressure area equipment and two hourly turns. One resident with a pressure area does not have pressure area management documented in the long term care plan and there has not been a review of the pressure area assessment tool since the development of the pressure area (link 1.3.5.2). There are four skin tears and four minor wounds in the hospital units. Short term care plans are in place for skin tears. One resident in the psychogeriatric unit has a wound with MRSA present. There is no alert or documentation to manage the infected wound in the care plan (link 1.3.5.2). Twenty staff attended wound care April 2013 and 19 staff in December 2013.  Continence products are available, resident files include, and management a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Twenty-three staff attended continence management in-services October/November 2013. The three unit co-ordinators interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse or other allied health or nursing specialists. Pain assessments have been completed on admission for all resident files sampled. There is an improvement required around the review of pain assessments.  There are a number of monitoring forms in place that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, food and drinks list, blood sugar monitoring, bowel records, continence diary and neurological observations. There is an improvement required around the use of behaviour monitoring charts, blood sugar monitoring recordings and documented interventions for weight loss. The previous audit identified corrective actions required around care plan interventions and these have not yet been fully addressed yet (link 1.3.5.2). |

##### **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Pain assessments have been completed on admission for all resident files sampled and reviewed six monthly. There are specific needs for dementia plans that include; environmental, ways in which the resident likes to express themselves, things that upset them, things that make them calm and things I can do (activities) over a 24 hour period. Behaviour monitoring charts are reviewed to assist in the development of a behaviour management plan. Behaviour monitoring is in place for residents who are having changes or reduction to psychotropic medications. Blood sugar monitoring charts are in place for diabetic residents as per the GP instructions. Any recordings outside of the normal limits are reported to the RN and managed according to the diabetes management policy. |
| **Finding:** |
| i) There is no pain assessment or the monitoring of pain for one hospital resident with a new episode of pain (as per GP notes). ii) There is no behaviour management plan or behaviour monitoring chart in place for one hospital resident with altered behaviours. iii) One rest home resident seen by the GP for an episode of aggressive behaviour does not have behaviour monitoring in place as requested by the GP (link 1.3.3). iii) One hospital resident known to have recent hypoglycaemic episodes (as per progress notes/medical notes) had not had daily sugar monitoring for seven consecutive days. |
| **Corrective Action:** |
| i) Ensure pain assessments and monitoring is completed for new episodes of pain. ii) Ensure behaviour monitoring and behaviour management plans are in place for residents with altered behaviours. iii) Ensure blood sugar monitoring frequency is carried out as instructed. |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service employs a qualified diversional therapist (DT) currently on leave and two activity assistants who both work 25 hours a week Monday to Friday. Two of the staff have completed the dementia course and the other staff member is progressing through the course. The activity team attend regular in-service on-site and attend the annual Bupa regional training day. The activity team meet monthly to plan the separate programmes for the upstairs, downstairs hospital wings, and the psychogeriatric unit.  Scheduled activities take place from 9 -10.30 , 11-12.15 and 13.00-14.00 but they are not limited to this. The activity cupboard and rummage boxes are left open and accessible and activities are continued throughout day by CG staff.  In addition the CG rostered in PG 16.30-20.30 works more in social activity role during this time as lounge activity nurse rather than limited to only hands on care. There are some residents who are also able to be taken out to the activities that occur in the hospital area at times. in the Shakespeare (psychogeriatric unit) and includes (but not limited to) painting, reminiscing, meaningful moments, skittles, pet therapy, beach themes (sand saucers, sand castles, beach ball games),crafts, happy hour, floral art and one on one time. The care staff have access to activity resources for use throughout the day and night as required. There is one morning and two afternoon van outings per week for Shakespeare residents. Van outings are offered twice a week in the rest home/hospital wings. There is a wheelchair van available. A designated driver and activity assistant accompany the residents on outings. The activity team have current first aid certificates. There is regular musical entertainment that is rotated through the different lounges and is open to all residents. Activities in the rest home and hospital area is designed to involve the residents as much as possible and include (but not limited to); puzzles, word games, board games, pet therapy, craft, bingo, movies, balloon volleyball, knitter/knatter group and bowls. One on one time and individual activities occurs. Community visitors such as library service, senior moments, stroke club, school children and choirs visit the residents regularly. Interdenominational church services are held twice monthly. The activity team meet with the families at least six monthly at the activity care plan review that occurs at the same time as the clinical long term care plan review. An activity assessment and map of life is completed on admission with resident/family participation. |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.4a: Care plans are evaluated by the RNs six monthly or when changes to care occur as sighted in six of seven care plans sampled (one psychogeriatric resident has not been at the service six months). The multidisciplinary review involves the RN, DT, unit co-ordinator and family/resident. The family are notified by phone call if they have been unable to attend the MDT (evidenced in the family contact form). From the sample group of residents notes there are short term care plans in use. Examples are; skin tears, UTI and toe infection. The short term care plans are evaluated and on-going problems are added to the long term care plan.  There is at least a one to three monthly review by the medical practitioner. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is one main medication room for the whole of the facility located in the downstairs hospital wing. There is a register of medicine competent RN’s and caregivers. RN’s have completed syringe driver education and competency in June 2013. This is The RN’s are supported by the local hospice nurses and specialists. There are current standing orders in place. There are no self-medicating residents. Regular medications are in robotic packs and PRN (as required) medications are kept in bottles with pharmacy labels. A medication reconciliation form is completed when medications are delivered. There is a monthly checklist of pharmaceuticals in stock and the expiry dates. There are no expired medications. All eye drops are dated on opening. This is an improvement since the previous audit. There are weekly controlled drug checks and a six monthly pharmacy audit last completed December 2013. The medication fridges temperature is monitored daily. The oxygen, suction and emergency equipment (upstairs and downstairs) is checked weekly. There are three oxygen concentrators available. The service is currently changing over the medication charts to pharmacy generated charts. There are no gaps in the signing sheets. PRN medications administered are dated and timed. Medication charts have photo identification and allergies noted. There are special precautions and instructions for administration for each resident medication chart. Eight of 14 medication charts have been changed over to the pharmacy generated chart and not due for GP review. Six of 14 medication charts have been reviewed three monthly by the GP. |

##### **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a six weekly rotating summer /winter menu, which is approved by a registered dietitian. The menu range is varied and appropriate to the resident group.  Personal preferences/likes/dislikes are noted on admission on the nutritional requirements form and the kitchen maintains a copy of these forms. Review of seven files showed that all seven nutrition profiles are up to date. Two residents and five family members interviewed all expressed satisfaction with food services.  Resident’s special food needs are noted on the white board for easy reference to all kitchen staff. There is evidence of special diets being provided in the facility such as vegetarian meals and modified diets for those residents at risk of food and fluid aspiration. The cook interviewed described how resident likes/dislikes and special diets were catered for and showed an improvement made since a complaint received in December 2013 about food services such as improvement around variety of food and individualised menu for some residents and use of scan box in meal delivery to the Waiti wing (located at second floor) .  Northhaven employs one cook, two weekend cooks and three cook assistants. All kitchen staff have completed food handling training.  Inspection of the kitchen evidenced equipment manuals available for use, routine cleaning schedules are in use and regular monitoring of temperatures for fridges and freezers occur. The temperature of cooked food is also routinely checked and documented before being served. The pantry is well stocked and managed with all food on appropriate shelving. Food safety audits were completed on February – May 2013 and showed 90% and 95% compliance respectively.  Staff received training around nutrition and hydration in August 2013. Residents (one rest home and three hospital) and families (five hospital) interviewed confirm that there are sufficient staff available at meal times for any resident requiring assistance and snacks are available for residents at all times. |

##### **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.

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

##### **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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 1.4.2: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a current building warrant of fitness. Six monthly fire drills are conducted the most recent being August 2013. There is a maintenance reporting system and a 52 week planned maintenance programme that includes monthly hot water temperature monitoring. External access to outdoor areas have keypad access. Residents and visitors are required to request the code to access external areas (link 2.1.1.4). |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

# 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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a documented definition of restraint and enablers. 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. Enablers are assessed as required for maintaining safety and independence. Enablers are used voluntarily. Monitoring of enabler and restraint use (bed rails) are monitored.  Implementation is reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level. Restraint use audit was completed in 2013 shows 95% compliance. Staff received training around restraint minimisation and enablers on 23 and 25 July 2013.  Restraint register shows that in the hospital, six bedrails are used as a restraint and five bed rails used as an enabler. In the PG unit, one bed rail is used as an enabler. Staff interview confirmed knowledge around enabler and restraint use and four caregivers interviewed confirmed that Northhaven do not use lap belt as a restraint and they all worked actively to achieve this goal. Staff stated that the use of side rails as restraint were solely around safety of the resident and described the events and risks involved prior the bedrails. The audit identified use of environmental restraint in the hospital/rest home wing. There was no evidence of a re-assessment done or documented interventions to manage the impact of environmental restraint. |

##### **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are two residents in the hospital wing that listed as using environmental restraint. The restraint policy stated that Northhaven is identified as one of three Bupa facilities to have a keypad entry and exit into the hospital/rest home wing. The Bupa restraint policy includes actions to be taken when environmental restraint is used including a) display of key pad numbers located in close proximity to the doors for ease of entry and exit by visitors and resident b) residents who are mobile but do not have the ability to operate the key pad will be assessed by the NASC agency as needing a safe environment but not requiring placement in psychogeriatric unit. c) This will be documented in their care plan and the need for this will be regularly reviewed. |
| **Finding:** |
| There is a keypad lock at the front door of the hospital and the code is not in sight. Therefore, residents and visitors cannot independently enter and exit the facility. A secure outdoor area in the hospital wing (second floor) has a keypad lock to exit to the courtyard that also has high fences. There is also a keypad entrance back into the facility from the courtyard. This restricts residents to use the outdoor area freely and potentially can lead a resident trapped in the outdoor area.  Advised that all residents, relatives and visitors must ask for codes to exit doors. As the units are secure, it makes it an environmental restraint for all residents. While Bupa have included environmental restraint in the restraint policy included management strategies. The service has only included two residents on the restraint register as environmental restraint. Those two residents do not have NASC re- assessment indicating they needed a safe environment and as their mobility has improved since their care plan lacks instructions for minimising the impact of environmental restraint. |
| **Corrective Action:** |
| Ensure that restraint minimisation policy around environmental restraint is fully implemented. Review the current environmental restraint. Ensure the two residents impacted by environmental restraint are reassessed |
| **Timeframe (days):** 30 *(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 3.5: 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| IC surveillance programme is appropriate to the size and complexity of the facility. Effective monitoring of IC is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and training. Surveillance data is available to all staff and staff interview confirmed understanding of the value of surveillance. There is an IC register that includes all infections and are documented monthly. Review of meeting minutes showed discussions around IC issues and alerts for staff. The IC is linked with the quality management programme and quality improvement initiatives are taken and recorded as part of continuous improvement. The most recent quality improvement activities around IC include (but is not limited to), a) purchase of new linen trolleys, b) increased training and random audits around hand hygiene, c) cranberry juice is used for prevention of UTI’s and d) increased frequency of toolbox talks are provided to staff around preventative actions. Benchmarking results for Jan-Dec 2013 shows low infection rates in all categories and well below the benchmarking mark compare to 11 other Bupa facilities.  Staff interview (four caregivers) confirmed staff knowledge around MRSA and ESBL. A further four resident files reviewed around documentation of IC showed appropriate detail of preventative interventions, resident training and specialist support. Resident’s files include alerts for MRSA and ESBL in the hospital/ rest home wings.  Internal infection control audits also assist the service in evaluating infection control needs.  Interview with IC coordinator and the four caregivers confirmed no outbreaks since the previous audit. |

##### **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.

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

##### **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.

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