# Bupa Care Services NZ Limited - Broadview Rest Home & Hospital

## Current Status: 17 March 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

Broadview Rest Home and Hospital is part of the Bupa group. The service provides hospital (36 beds), rest home (14 beds), hospital level mental health (10 beds), dementia (15 beds) and psychogeriatric (10 beds) level care for up to 85 residents. On the day of audit, there was a total of 71 residents – 11 at rest home level care, 15 at dementia level care, 9 in the mental health unit, 10 at psychogeriatric level care and 26 at hospital level care.

A registered nurse who was previously the clinical manager for many years manages Broadview Rest Home and Hospital. She has been in this role since August 2013. A clinical manager (a registered nurse who has been at the facility for five years and in this role since August 2013), two unit coordinators (registered nurses) and Bupa regional manager (registered nurse) also support her. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Family and residents interviewed spoke positively about the service provided.

The five shortfalls identified in the previous audit have been addressed. These are around use of the restraint, documentation of emergency restraint, medication management and the building warrant of fitness.

This surveillance audit identified improvements required around wound management, assessment of residents admitted for mental health assessment, care planning, interventions, informing staff of quality data analysis and staff education.

## Audit Summary as at 17 March 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 17 March 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 17 March 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 17 March 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 17 March 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 17 March 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. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 17 March 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. |

## Audit Results as at 17 March 2014

### Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter’s policy is in place. Family members and staff, from a range of cultures, are the most common source of interpreter services within the facility. External assistance is available if necessary.

The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. A complaints register is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are managed.

### Organisational Management

Broadview Rest Home and Hospital has an established quality and risk management system. Quality and risk performance is reported to the organisation's management team. There is an improvement required around staff consistently being informed of quality data trend analysis and outcomes. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Broadview Rest Home and Hospital is benchmarked in all of these. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and the requirements. However, improvements are required around staff attendance at trainings and appropriate staff having first aid certificates.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. The 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.

### Continuum of Service Delivery

A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans overall demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around assessment of residents admitted to the mental health unit for assessment, care planning, two hourly turning, nursing interventions and wound management.

Medication policies reflect legislative requirements and guidelines. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.

The activities programme is facilitated by an activities team and residents and families report satisfaction with the activities programme. In the psychogeriatric unit, activities are also provided on a one to one basis including individual outings. The programme includes significant community engagement including competitions with other aged care facilities in the area. An activities plan is developed by the diversional therapist for the dementia and psychogeriatric units and this is mostly implemented by caregivers. Residents are taken also to shared programmes in the Victoria lounge where they have the opportunity to participate, facilitated by activities staff. All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

### Safe and Appropriate Environment

Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. The building holds a current warrant of fitness. A kitchenette has been built in the dementia unit so that the night staff do not have to leave the unit to prepare drinks or snacks for residents through the night and following a power outage the service has a generator on standby and able to be easily accessed in the event of future power failure.

### Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has ten residents using restraint and four residents using enablers. Training has been provided around restraint, enablers and challenging behaviours. Improvements have been made since the previous audit around the documentation of emergency restraint.

### Infection Prevention and Control

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections, which have been completed in 2013 and 2014 to date as per internal audit schedule.

Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

# HealthCERT Service Provider Audit Report (version 5.91)

## **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 a health and disability 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 - Broadview Rest Home & 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:** | Broadview Rest Home & Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services and psychogeriatric; Rest home care and dementia care | | | |
| **Dates of audit:** | **Start date:** | 17 March 2014 | **End date:** | 18 March 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:** | 71 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 10 | **Total hours off site** | 4 |
| **Technical Experts** | XXXXX | **Total hours on site** | 5 | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 31 | Total audit hours off site | 15 | Total audit hours | 46 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents/patients interviewed | 6 | Number of staff interviewed | 19 | Number of managers interviewed | 3 |
| Number of residents’/patients’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 87 | Number of relatives interviewed | 7 |
| Number of residents’/patients’ records reviewed using tracer methodology | 5 |  |  | Number of GPs interviewed (Residential Disability providers only) | 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 the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of the DAA | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAA 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) | the DAA has provided all the information that is relevant to the audit | Yes |
| h) | the DAA has finished editing the document. | Yes |

Dated Thursday, 8 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Broadview Rest Home and Hospital is part of the Bupa group. The service provides hospital (36 beds), rest home (14 beds), hospital level mental health (10 beds), dementia (15 beds) and psychogeriatric (10 beds) level care for up to 85 residents. On the day of audit, there were 71 residents – 11 at rest home level care, 15 at dementia level care, nine in the mental health unit, 10 at psychogeriatric level care and 26 at hospital level care. Four of the residents in the mental health unit are under 65 years old.  A registered nurse who was previously the clinical manager for many years manages Broadview Rest Home and Hospital. She has been in this role since August 2013. A clinical manager (a registered nurse who has been at the facility for five years and in this role since August 2013), two unit coordinators (registered nurses) and Bupa regional manager (registered nurse) also support her. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Family and residents interviewed spoke positively about the service provided. The five shortfalls identified in the previous audit have been addressed. These are around use of the four-figure restraint, documentation of emergency restraint, medication management and the building warrant of fitness. This surveillance audit identified improvements required around wound management, assessment of residents admitted for mental health assessment, care planning, interventions, informing staff of quality data analysis and staff education. |

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| **Outcome 1.1: Consumer Rights** |
| Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter’s policy is in place. Family members and staff, from a range of cultures, are the most common source of interpreter services within the facility. External assistance is available if necessary. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. A complaints register is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are managed. |

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| **Outcome 1.2: Organisational Management** |
| Broadview Rest Home and Hospital has an established quality and risk management system. Quality and risk performance is reported to the organisation's management team. There is an improvement required around staff consistently being informed of quality data trend analysis and outcomes. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Broadview Rest Home and Hospital is benchmarked in all of these. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.  There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and the requirements. However, improvements are required around staff attendance at trainings and appropriate staff having first aid certificates. The organisational staffing policy aligns with contractual requirements and includes skill mixes. The 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. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans overall demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around assessment of residents admitted to the mental health unit for assessment, care planning, two hourly turning, nursing interventions and wound management. Medication policies reflect legislative requirements and guidelines. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.  The activities programme is facilitated by an activities team and residents and families report satisfaction with the activities programme. In the psychogeriatric unit, activities are also provided on a one to one basis including individual outings. The programme includes significant community engagement including competitions with other aged care facilities in the area. An activities plan is developed by the diversional therapist for the dementia and psychogeriatric units and this is mostly implemented by caregivers. Residents are taken also to shared programmes in the Victoria lounge where they have the opportunity to participate, facilitated by activities staff. Eg Indoor bowls and external entertainers. All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. The building holds a current warrant of fitness. A kitchenette has been built in the dementia unit so that the night staff do not have to leave the unit to prepare drinks or snacks for residents through the night and following a power outage the service has a generator on standby and able to be easily accessed in the event of future power failure. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are clear guidelines in policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has 10 residents using restraint and four residents using enablers. Training has been provided around restraint, enablers and challenging behaviours. Improvements have been made since the previous audit around the documentation of emergency restraint. |

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| **Outcome 3: Infection Prevention and Control** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections, which have been completed in 2013 and 2014 to date as per internal audit schedule.  Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 15 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 48 | 0 | 1 | 3 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 38 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 89 |

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

| **Code** | **Name** | **Description** | **Attainment** | | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | | Quality data is analysed and results are discussed at quality meetings. These are not always discussed at staff or senior staff meetings. While the quality meeting minutes are placed in a folder in the staff room for staff to read, not all staff read these as evidenced in staff interviews. It is noted that benchmarking results are placed in the relevant service areas but discussion of the results of these with all staff is not always evident. | Ensure the results of quality data analysis and evaluation are communicated to all staff. | 180 |
| 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 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | | (i)Attendance at staff education sessions including core trainings is very low with less than 20% of staff having attended any one training. (ii) Two caregivers who regularly take residents from the psychogeriatric and mental health units on individual outings do not have first aid certificates. (iii) Three employees who have worked in the psychogeriatric unit for more than one year have not completed the required dementia standards. | (i)Ensure that relevant staff are encouraged to attend the training provided at the facility; (ii) Ensure all staff who take residents out of the facility have a first aid certificate. (iii) Ensure all staff working in the psychogeriatric unit have completed the required dementia standards. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.4 | The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate. | PA Moderate | | There is no documented early warning signs or relapse prevention plan documented in the file sampled from the mental health unit. | Ensure all residents in the mental health unit have early warning signs and a relapse prevention plan documented. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA 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)Of the 13 wounds at the facility, seven have not been reviewed in the stated timeframe (six from Victoria hospital and one from the rest home). It is noted that six of these wounds are pressure areas. (ii) one resident from the mental health unit is in the unit on an assessment contract for mental health assessment. (a) There has been no formal monitoring of behaviours or mental health symptoms documented. (b) While the resident has been visited regularly by the psychogeriatrician and the community mental health nurse there has been no formal multidisciplinary review of his mental health as part of the assessment process. (c) There has been no evaluation of the effectiveness of interventions as would be expected for a resident undergoing an assessment. (d) There is no documented early warning signs or relapse prevention plan. (e) The resident had a significant deterioration in mental health (such that he required feeding) in February 2013 but no short term care plan was developed. There was no short term care plan around this or when the resident contracted pneumonia. (f) The resident has lost 15kg since admission. His brother reports this is a positive factor, however, the care plan does not include any interventions around weight management. (g) The resident is diabetic and on oral medication. Regular blood sugar readings were discontinued by the GP but when the resident became unwell and was eating and drinking minimal amounts, blood sugar reading were not documented. (h) There is little documentation in the progress notes of the resident’s mental health or other progress following a significant medication change in February 2014. (iii) one resident has congestive heart failure and on 3 March 2013, (a) The GP requested he be weighed weekly and that his fluids be restricted to 1500 mls. This is not documented on a short term care plan and the care summary states ‘free fluids’. (b) The resident has depression and this is not addressed in the care plan. (iv) One hospital resident was admitted on 5 February 2013. (a) The resident has not yet had a long term care plan developed. (b) The care summary is not an accurate reflection of the resident’s current needs. (c) The resident experiences shortness of breath and has experienced a seizure since her admission. Neither of these issues are addressed in a care plan. (d) The resident has not had a nutrition assessment. (e) The resident has a pressure area and requires two hourly turns. The turning chart shows she was not turned between 0800 hours on 16 March 2014 and 0400 hours on 17 March 2014. | | (i)Ensure that all wounds are reviewed within the stated timeframe. (ii) Ensure that short term care plans are developed for short term needs. (iii) Ensure that residents admitted for MH assessment have a thorough assessment including monitoring of symptoms and behaviours, regular evaluation of effectiveness of cares and regular multi-disciplinary reviews. (iv) Ensure progress notes reflect a resident’s condition when there has been a medication change. (v) Ensure all resident s have a long term care plan developed within three weeks of admission. (vi) Ensure care summaries accurately reflect resident’s needs. (vii) Ensure all identified issues are addressed in long term care plans. (viii) Ensure residents are turned regularly when they require this. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Six registered nurses (three from the hospital, one from the dementia unit and two who work in the mental health and psychogeriatric units) and the clinical nurse manager interviewed stated that they record contact with family/whanau on the family/whanau contact record (sighted). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. A sample of incident forms reviewed for January 2014 from across all areas identified on 13 of 13 incident forms that family were informed. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in April 2013 at Broadview with a result of 93.75%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files. D16.4b The seven relatives (one from the rest home, one from the psychogeriatric unit, one from the dementia unit, one from the mental health unit and three from the hospital) interviewed stated that they are always informed when their family members health status changes.  There is a Bupa residents/relatives association that provides a strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. Feedback is provided to Broadview residents. The interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and government agencies is available. In addition, a number of staff is able to assist with interpreting for care delivery. A policy on contact with media is also available.   D12.1 Non-Subsidised residents/EPOA is 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. ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia 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. D11.3 The information pack is available in large print and advised that this can be read to residents. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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 1.1.9.4 (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:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet. There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and prominent around the facility on noticeboards.  A complaints register is up to date and includes relevant information regarding the complaint (there have been two complaints in 2014 to date). Documentation including follow-up letters or meetings and resolution demonstrates that complaints are well managed. Verbal complaints are encouraged and actions and response are documented. Discussion with seven relatives confirmed they were provided with information on complaints and complaints forms are available at the entrance. Three relatives described having concerns addressed immediately when brought up with management.   There have been three complaints to the DHB since the previous audit, two of which were also submitted to the Health and Disability Commission. The DHB visited on 26 February 2014 relating to one complaint and recommendations included ensuring full investigation of all complaints, ensuring all incidents are investigated and results reported back to staff (link 1.2.3.6), further dementia education for staff (link 1.2.7.5), rotating staff through shifts. Following, this complaint a kitchenette has been built and is operational in the dementia unit so that staff can provide hot drinks and snacks to residents without leaving the unit. Since the draft report, the service advised that the fridge is now installed. The second complaint related to the service not having a generator during a power outage. Following this complaint, the service has an arrangement with an external provider to have a generator on standby should it be needed. The third complaint related to the care of a resident and information to the family following a resident falling in the psychogeriatric unit. Corrective actions resulting from this complaint have included all qualified staff having read and signed the falls management, the registered nurse concerned completed a performance improvement plan and has completed a personal reflection, all staff were informed around pain assessments at a debrief meeting following the incident on 30 April 2013 and also a memo to all staff around pain assessments was circulated on 1 May 2013. ARHSS D13.3g: The complaints procedure is provided to relatives on admission. E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:  1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. |

##### **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:** |
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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 1.1.13.3 (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:** |
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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 1.2: 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Broadview Rest Home and Hospital is part of the Bupa group. The service provides hospital (36 beds), rest home (14 beds), hospital level mental health (10 beds), dementia (15 beds) and psychogeriatric (10 beds) level care for up to 85 residents. On the day of audit, there were 71 residents – 11 at rest home level care, 15 at dementia level care, nine in the mental health unit, 10 at psychogeriatric level care and 26 at hospital level care. Four of the residents in the mental health unit are under 65 years old.  Broadview Rest Home and Hospital is managed by a registered nurse who was previously the clinical manager for many years. She has been in this role since August 2013. A clinical manager (a registered nurse who has been at the facility for five years and in this role since August 2013), two unit coordinators (registered nurses) and Bupa regional manager (registered nurse) also support her.   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 Broadview Rest Home and Hospital has developed an annual quality plan. Broadview has set specific quality goals for 2013 including (but not limited to); a) consolidating the infection control committee to be more effective, b) reducing antipsychotic use in the psychogeriatric unit, c) reducing the falls rate in the dementia unit and d) increasing the home like environment. Broadview Rest Home and Hospital also has a specific mission statement for the mental health unit, which is to ‘provide a service which emphasises on recovery-focussed mental health services based on the perception that people are different. Therefore, our services are aimed at providing support to enhance the ability of individual service users (and their family/whanau) to identify their own keys to well-being, manage their own illness and activate and achieve life goals’. The service is also undertaking a review of the mental health unit to continue to look at a more recovery focussed service. The review has included meetings with staff, staff surveys, observations of the environment and residents and monitoring of challenging behaviours and PRN medication use. Following this, an action plan has been developed that includes three domains: education delivery for health literacy on mental health, improvement of the environmental space to provide more home like living, and review of employment criteria for the mental health certificate.  Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.  There is an overall Bupa business plan and risk management plan. Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider is on-going at Broadview Rest Home and Hospital. This has resulted in improvements to practice as quality improvement plans are developed if ever Broadview’s results are outside Bupa’s approved threshold for the indicator.  Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes are implemented at all sites including Broadview. Bupa has robust quality and risk management systems implemented at Broadview. Internal audits are completed and all quality data and initiatives and data discussed at facility meetings (minutes sighted). Specific issues identified in Health & Disability Commission (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 who meet two monthly. The aim is to review the past and looking forward. Specific issues identified in Health & Disability Commission (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 who meet two monthly  The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the director care homes. The Bupa managers in the region teleconference weekly. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Broadview Rest Home and Hospital and forwarded to the Bupa quality and risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals.   Broadview continues to implement the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. 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. Managers and clinical managers attend annual organisational forums and regional forums six monthly. ARC E2.1, 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Broadview Rest Home and Hospital has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, on the noticeboard and to the organisation's management team. However, while quality data is analysed and results are discussed at quality meetings, these are not always discussed at staff or senior staff meetings. While the quality meeting minutes are placed in a folder in the staff room for staff to read, not all staff read these as evidenced in staff interviews. It is noted that benchmarking results are placed in the relevant service areas but discussion of the results of these with all staff was not always evident.  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. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would be decided. These group members are asked to feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the quality and risk team.  Key components of the quality management system link to the monthly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and monthly quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected and staff incidents/accidents; b) The service has linked the complaints process with its quality management system; c) There is a quarterly infection control (IC) committee at Broadview. 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. d) Health and safety committee meets quarterly and is 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 health and safety coordinator. Any serious incident at any facility is reported to all Bupa facilities as memos/warnings. Annual analysis of results is completed and provided across the organisation. e) The facility restraint meeting meets monthly as part of the quality meeting and the Bupa regional restraint approval group meets six monthly.  There is an implemented internal audit programme. 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 Broadview 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 manager, which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / health & safety staff indicators etc. throughout the year. (Operations manager’s monthly summaries).  D19.3: There is a comprehensive health & safety and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a health & safety coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2014. On-going review of these objectives for Broadview is documented in health & safety meeting minutes.  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:** PA Low |
| **Evidence:** |
| Broadview Rest Home and Hospital has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, on the noticeboard and to the organisation's management team. Key components of the quality management system link to the monthly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and monthly quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected and staff incidents/accidents; b) The service has linked the complaints process with its quality management system; c) There is a quarterly infection control (IC) committee at Broadview. |
| **Finding:** |
| Quality data is analysed and results are discussed at quality meetings. These are not always discussed at staff or senior staff meetings. While the quality meeting minutes are placed in a folder in the staff room for staff to read, not all staff read these as evidenced in staff interviews. It is noted that benchmarking results are placed in the relevant service areas but discussion of the results of these with all staff is not always evident. |
| **Corrective Action:** |
| Ensure the results of quality data analysis and evaluation are communicated to all staff. |
| **Timeframe (days):** 180 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3c: The service collects incident and accident data. The category one incidents policy (044) includes responsibilities for reporting category (CAT) one incidents. The competed 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)". There have been three category one incidents at Broadview in 2014 to date.  D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.  Thirteen of 13 incident forms reviewed for January 2014 from across all areas identified that all demonstrated clinical follow up by a registered nurse and monitoring (such as neuro obs) having been undertaken when indicated.  Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |

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

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

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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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A register of registered nurse and enrolled nurse practising certificates is maintained at facility level. Within Bupa, website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / links). There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six files reviewed files (clinical nurse manager, registered nurse, two caregivers, the diversional therapist and the cook) and all had up to date performance appraisals. All staff files included a personal file checklist.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, registered nurse four weeks); during this period, they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (nine caregivers and six registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Interviews with the clinical nurse manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with core competencies level three unit standards. (These align with Bupa policy and procedures).   There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care - eg. Dementia, delirium and care planning. There is evidence on registered nurse staff files of attendance at the registered nurse training day/s and external training. Attendance at staff education sessions including core trainings is very low with less than 20% of staff having attended any one training. Two caregivers who regularly take residents from the psychogeriatric and mental health units on individual outings do not have current first aid certificates. These are areas requiring improvement. Bupa has recently begun developing competency workbooks around core education topics and the clinical nurse manager reports he intends to use these to ensure staff who do not attend training have a full knowledge of the subject area. 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.  A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.   D17.7d: Registered nurse 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. E4.5f. There are 25 caregivers that work in the dementia units. Twenty-three have completed the required dementia standards and two caregivers who have been at the service less than six months have commenced the course. Of the 11 caregivers who work in the eight have completed the dementia standards. The three staff that have not have been at the service longer than one year. This is an area requiring improvement.  There are 18 caregivers who work in the mental health unit. Fourteen have completed a mental health certificate and one of the remaining four is enrolled. |

##### **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:** 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 1.2.7.4 (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:** PA Moderate |
| **Evidence:** |
| There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care - eg. Dementia, delirium and care planning. There is evidence on registered nurse staff files of attendance at the registered nurse training day/s and external 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.  A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.   D17.7d: Registered nurse 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. E4.5f. There are 25 caregivers that work in the dementia units. Twenty-three have completed the required dementia standards and two caregivers who have been at the service less than six months have commenced the course. Of the 11 caregivers who work in the eight have completed the dementia standards. |
| **Finding:** |
| (i)Attendance at staff education sessions including core trainings is very low with less than 20% of staff having attended any one training. (ii) Two caregivers who regularly take residents from the psychogeriatric and mental health units on individual outings do not have first aid certificates. (iii) Three employees who have worked in the psychogeriatric unit for more than one year have not completed the required dementia standards. |
| **Corrective Action:** |
| (i)Ensure that relevant staff are encouraged to attend the training provided at the facility; (ii) Ensure all staff who take residents out of the facility have a first aid certificate. (iii) Ensure all staff working in the psychogeriatric unit have completed the required dementia standards. |
| **Timeframe (days):** 90 *(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.

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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 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. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours. The roster is flexible to allow for the increase of numbers of residents. All units are staffed separately with some night shift staff floating between units. A review of the roster indicates that there was one shift where a sick caregiver could not be replaced in the previous two weeks meaning that there were three caregivers on the evening shift that day in the hospital instead of four. For all other caregiver shifts, whenever a caregiver has been unable to attend there is a replacement caregiver found. There is a registered nurse in the hospital 24 hours per day with two on the morning shift (rolling rostered UC and RN. On the UC’s day off there is one RN).  There is also a registered nurse who covers the dementia unit and rest home five days per week (Sun-Thurs), noting that for the week beginning 10 March this registered nurse covered the mental health unit for two days. In addition, there is a registered nurse rostered 24 hours per day in the mental health/psychogeriatric unit (the two units are designed so they share an office and the office looks out over both day rooms. On the week, beginning 10 March the manager was unable to source a registered nurse for two night shifts in the mental health/psychogeriatric units. For one of these shifts an enrolled nurse provided cover. The DHB was informed of this event via email on 18 March 2014 (email sighted including response from DHB). It is noted there was still a registered nurse in the hospital during these shifts. A kitchenette has recently been installed in the dementia unit so night staff do not leave the unit unattended when they need to provide a resident with a hot drink or snack overnight. Interviews with nine caregivers (working across the services on morning, afternoon and nights) confirmed that staffing numbers were satisfactory. Interviews with eight residents (five rest home and three hospital) and three relatives (two hospital and one rest home) had no concerns about staffing levels.. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The staff and facilities are appropriate for providing rest home, hospital, psychogeriatric, dementia and mental health services.  The registered nurses complete resident assessments on admission and clinical evaluations at least six monthly.  Six resident files sampled (one rest home, one hospital, two dementia, one mental health and one psychogeriatric) identified that in six of six files an initial assessment was completed within 24 hours. In five of the six files sampled, the long term care plan was completed within three weeks. There is evidence of resident and/or family/whanau/EPOA involvement in the care planning process.  There is no long term care plan developed for the hospital resident admitted over three weeks ago (link 1.3.6.1). Nine care staff (working across the services on morning, afternoon and nights) described comprehensive handovers for all RNs and the caregiving team at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. There is a written handover sheet, verbal handover and a physical round conducted at each change of shift. Progress notes are written every shift.   Medical assessments are completed on admission by the general practitioner (GP) with two working days in six of six residents files sampled. Medical reviews are at least three monthly or earlier as indicated by the GP. The GP has input into the six monthly reviews. The GP interviewed practices in a local health centre and visits the service twice weekly. Routine three monthly reviews are completed and residents of concern are seen and examined on clinic days or earlier as required. The GP meets with families at the facility as required. The GP states RN clinical assessments are good and all calls made to him are appropriate. There is clear communication between the RNs, the practice nurse and the GP. The GP is available on mobile phone until 10pm and the emergency department is contacted during the night as required. A locum GP is provided for GP leave.   ARHSS D16.6; One resident file for a resident with behaviours that challenge was reviewed from the psychogeriatric unit. The behaviours are well identified through the assessment process with triggers for behaviours, interventions and management documented in the long term care plan. Behaviour monitoring and progress notes are completed for new or acute behaviours. There is evidence of a psychiatric review and medication review. The psychiatrist visits weekly. The mental health assessment and treatment team (MHAT) contact numbers are readily available.   Tracer methodology: Psychogeriatric unit. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology: Dementia unit.  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology hospital:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology rest home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology mental health unit:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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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:** |
|  |
| **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.)* |

##### **Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)**

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

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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 1.3.3.6 (HDS(C)S.2008:1.3.3.6)**

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for 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 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| One file was sampled from the mental health unit for a resident on a short term admission assessment. A long term care plan has been developed that documents the residents preferences and includes interventions for all identified needs including the management of mental health symptoms. A risk assessment has been completed by the mental health service for older people, however, there is no documented early warning signs or relapse prevention plan documented and this is an area requiring improvement. |

##### **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:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **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 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

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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 1.3.5.4 (HDS(C)S.2008:1.3.5.4)**

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| One file was sampled from the mental health unit for a resident on a short term admission assessment. A long term care plan has been developed that documents the residents preferences and includes interventions for all identified needs including the management of mental health symptoms. A risk assessment has been completed by the mental health service for older people. |
| **Finding:** |
| There is no documented early warning signs or relapse prevention plan documented in the file sampled from the mental health unit. |
| **Corrective Action:** |
| Ensure all residents in the mental health unit have early warning signs and a relapse prevention plan documented. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Residents’ care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by the clinical manager in all five areas. One resident has not had a long term care plan developed within three weeks of admission and has seizures and shortness of breath, which are not addressed in the care plan.  One mental health resident has weight management issues that are also not addressed in the long term care plan. These are areas requiring improvement.   Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes sighted – one from the mental health unit, one from the psychogeriatric unit, two from the dementia unit, one from the hospital and one from the rest home). The mental health resident’s progress notes do not document the impact of a significant medication change. This is also an area requiring improvement.   When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The nine caregivers interviewed (three who work across all areas, three who work in the mental health/psychogeriatric units and three who work in the hospital) stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted.   Six residents interviewed (two hospital, two mental health and two rest home) and seven relatives (one from the rest home, one from the psychogeriatric unit, one from the dementia unit, one from the mental health unit and three from the hospital) were complimentary of care received at the facility.  The care being provided is generally consistent with the needs of residents, this is evidenced by discussions with nine caregivers, seven families interviewed, six registered nurses (three from the hospital, one from the dementia unit and rest home and two who from the psychogeriatric/mental health units), the facility manager and the clinical nurse manager. However, the mental health resident did not have blood sugar readings taken despite being a diabetic and becoming unwell and the two hourly turning chart of the hospital resident indicates two hourly turns are not always maintained. These are further areas requiring improvement.   The resident from the mental health unit is in the unit on an assessment contract for mental health assessment. There has been no formal monitoring of behaviours or mental health symptoms documented. While the resident has been visited regularly by the psychogeriatrician and the community mental health nurse there has been no formal documented multidisciplinary review of his mental health as part of the assessment process. There has been no evaluation of the effectiveness of interventions as would be expected for a resident undergoing an assessment. These are further areas requiring improvement. There is a short-term care plan that is used for acute or short-term changes in health status with some exceptions. This is an area requiring improvement.  The previous audit identified shortfalls around the management of the four figure restraint. However, this restraint was last used as an emergency in March 2013 and staff report they are no longer permitted to use this form of restraint. Therefore, the previous issues have now been addressed.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided.  Wound assessment and wound management plans are in place for 13 residents. This includes seven pressure areas in the hospital. Staff training around wound management occurred throughout 2013. Seven of the 13 wounds have not been reviewed in the timeframe stated (six from Victoria wing– hospital and one from the rest home). Six of these wounds are pressure areas. This is also an area requiring improvement. The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.  ARHSS D16.4; There is good specialist input into residents in the psychogeriatric a unit. A mental health consultant visits as required, psychogeriatrician visits weekly and community mental health nurse visits weekly from mental health services for older people. Strategies for the provisions of a low stimulus environment could be described.  The facility has registered nurse cover 24/7 (link 1.2.8.1) and has an ‘in service’ education programme (link 1.2.7.5).  A record of all health practitioners practicing certificates are kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by an R.N.  During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation. |

##### **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:** |
| Residents’ care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by the clinical manager in all five areas. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes sighted – one from the mental health unit, one from the psychogeriatric unit, two from the dementia unit, one from the hospital and one from the rest home). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The nine caregivers interviewed (three who work across all areas, three who work in the mental health/psychogeriatric units and three who work in the hospital) stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Six residents interviewed (two hospital, two mental health and two rest home) and seven relatives (one from the rest home, one from the psychogeriatric unit, one from the dementia unit, one from the mental health unit and three from the hospital) were complimentary of care received at the facility. The care being provided is generally consistent with the needs of residents, this is evidenced by discussions with nine caregivers, seven families interviewed, six registered nurses (three from the hospital, one from the dementia unit and rest home and who from the psychogeriatric/mental health units), the facility manager and the clinical nurse manager. |
| **Finding:** |
| (i)Of the 13 wounds at the facility, seven have not been reviewed in the stated timeframe (six from Victoria hospital and one from the rest home). It is noted that six of these wounds are pressure areas. (ii) The resident from the mental health unit is in the unit on an assessment contract for mental health assessment. (a) There has been no formal monitoring of behaviours or mental health symptoms documented. (b) While the resident has been visited regularly by the psychogeriatrician and the community mental health nurse there has been no formal multidisciplinary review of his mental health as part of the assessment process. (c) There has been no evaluation of the effectiveness of interventions as would be expected for a resident undergoing an assessment. (d) There is no documented early warning signs or relapse prevention plan. (e) The resident had a significant deterioration in mental health (such that he required feeding) in February 2013 but no short term care plan was developed. There was no short term care plan around this or when the resident contracted pneumonia. (f) One resident has lost 15kg since admission. His brother reports this is a positive factor, however, the care plan does not include any interventions around weight management. (g) The resident is diabetic and on oral medication. Regular blood sugar readings were discontinued by the GP but when the resident became unwell and was eating and drinking minimal amounts, blood sugar reading were not documented. (h) There is little documentation in the progress notes of the resident’s mental health or other progress following a significant medication change in February 2014. (iii) A rest home resident has congestive heart failure and on 3 March 2013, (a) The GP requested he be weighed weekly and that his fluids be restricted to 1500 mls. This is not documented on a short term care plan and the care summary states ‘free fluids’. (b) The resident has depression and this is not addressed in the care plan. (iv) The hospital resident was admitted in February 2013. (a) The resident has not yet had a long term care plan developed. (b) The care summary is not an accurate reflection of the resident’s current needs. (c) The resident experiences shortness of breath and has experienced a seizure since admission. Neither of these issues are addressed in a care plan. (d) The resident has not had a nutrition assessment. (e) The resident has a pressure area and requires two hourly turns. The turning chart shows she was not turned between a 0800 hours and 0400 hour period. |
| **Corrective Action:** |
| (i)Ensure that all wounds are reviewed within the stated timeframe. (ii) Ensure that short term care plans are developed for short term needs. (iii) Ensure that residents admitted for MH assessment have a thorough assessment including monitoring of symptoms and behaviours, regular evaluation of effectiveness of cares and regular multi-disciplinary reviews. (iv) Ensure progress notes reflect a resident’s condition when there has been a medication change. (v) Ensure all resident s have a long term care plan developed within three weeks of admission. (vi) Ensure care summaries accurately reflect resident’s needs. (vii) Ensure all identified issues are addressed in long term care plans. (viii) Ensure residents are turned regularly when they require this. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)**

The consumer receives the least restrictive and intrusive treatment and/or support possible.

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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 1.3.6.5 (HDS(C)S.2008:1.3.6.5)**

The consumer receives services which:  
(a) Promote mental health and well-being;  
(b) Limit as far as possible the onset of mental illness or mental health issues;  
(c) Provide information about mental illness and mental health issues, including prevention of these;  
(d) Promote acceptance and inclusion;  
(e) Reduce stigma and discrimination.   
This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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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 1.3.7: 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are four activity staff including two diversional therapists. One activities coordinator provides activities in the dementia unit, which are planned with supervision from the diversional therapist. Extra activities are also provided by caregivers. In the psychogeriatric unit and mental health unit most of the activities are run by the caregivers and this includes 1:1 outings individualised to the resident’s interests. The activities coordinators and diversional therapists have training around dementia care and needs.  The programme offered primarily in the rest home and hospital is inclusive for all residents and staffing is sufficient to supervise residents from the dementia unit, psychogeriatric unit and mental health units who attend activities they might enjoy in the rest home and hospital. On the day of audit, residents in all areas were observed being actively involved with a variety of activities at different levels. In the mental health unit on the first days resident were watching TV and on the second day they were involved in word games and several attended entertainment in the hospital lounge. Caregivers were witnessed to provide a varied programme in the dementia, mental health and psychogeriatric units. The programme is developed monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.   D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review/evaluated. The programme includes networking within the community with social clubs, schools etc. On or soon after admission, a social history is taken and information from this is fed into the lifestyle plan and this is reviewed six monthly as part of the lifestyle care plan review/evaluation. A record is kept individual residents activities. There are recreational progress notes in the resident’s file that the activity coordinators or diversional therapists complete for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in all areas of the facility, participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.  Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit and psychogeriatric unit, which are conducted by care staff out of normal hours. There is a resource cupboard in each of these units where caregivers (or visitors) can access activities to complete with residents. The activities coordinator has attended Bupa training around providing activities in a dementia unit.  D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered, is included in the lifestyle care plan. Residents are quick to feedback likes and dislikes to the activity staff. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly. ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur as sighted in six of six files sampled. There is at least a one- three monthly review by the medical practitioner.  There are short term care plans to focus on acute and short-term issues (link 1.3.6.1). Changes to the long term care plan are made as required and at the six monthly review if required (link 1.3.6.1). Examples of STCPs in use included; infections, wounds, challenging behaviours, and unexplained weight loss. Care plans are evaluated six monthly more frequently when clinically indicated. ARC: ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission (link 1.3.6.1). |

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

##### **Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)**

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if 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 1.3.10: Transition, Exit, Discharge, Or Transfer **(**HDS(C)S.2008:1.3.10)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made. There have been no discharges from the mental health unit to the community since the previous audit. Residents leaving the mental health unit have been transferred to another unit at Broadview or to another aged care facility. The registered nurses at Broadview interviewed report when a resident is transferred from the mental health unit to another unit a comprehensive handover is provided. |

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

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

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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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Each unit has a medication room, with the exception of the psychogeriatric and mental health unit that share a medication room closely located to the shared nurse’s station. All medications are stored in locked rooms. Returns are stored safely until collected by the supplying pharmacy. Regular medications are dispensed in robotic rolls. All medications are checked on delivery by the RN on duty. Robotic checking forms are completed (sighted). PRN medications are blister packed. PRN supplies and expiry dates are checked weekly. Only the RNs have access to medication rooms. There is a register of medication competent staff. RN’s, enrolled nurses and senior caregivers complete annual competencies and education to administer medications. Competencies include oral medications, nebulisers, and blood sugar monitoring, subcutaneous and intramuscular injections. RN’s complete syringe driver competencies. Standing orders are reviewed annually. The standing orders were removed from the mental health unit during the audit as these were inappropriate for this service. All eye drops in use are dated. This is an improvement from the previous audit. Medication fridges are monitored weekly. All controlled drugs are checked weekly. There is a six monthly pharmacy audit. There is one self-medicating resident on GTN. The resident has signed a consent form and the GP has signed for resident competency. The GP reviews the self-medication status three monthly. Oxygen and suction is available in the event of an emergency.  Twelve medication charts sampled (two mental health, two psychogeriatric, two hospital, two rest home, four dementia) are all correctly signed as per GP prescription. This is an improvement since the previous audit. Each resident has an antipsychotic management plan. The use of PRN antipsychotics are documented on the behaviour monitoring form and in the progress notes. This is an improvement from the previous audit. The service is proactive in reducing the use of antipsychotic medication. The resident (where appropriate) and family/whanau are consulted regarding the commencement, review and discontinuation of medications.  All 12 medication charts had photo identification and allergy status noted. There is evidence of three monthly GP review. |

##### **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.)* |

##### **Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)**

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

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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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A head cook and relieving cook cover the seven days week with a cook assistant and kitchen assistant on mornings and a tea cook in the evening. There is a six week rolling menu. The menu has been developed by the company dietitian. There is a monthly teleconference with the dietitian. All cooks attend the annual regional Bupa kitchen lead days. The cook receives a resident nutritional requirement list. Updates and dietary changes are communicated to the kitchen. Resident’s likes and dislikes are known. All diets are accommodated such as pureed, normal, diabetic and allergies. Special lip plates and utensils are available for residents to help promote independence with meals. The kitchen is located on the ground floor. Meals are delivered to the units, plated and in hot boxes. Food temperatures are taken on all foods on one day per week. Daily fridge and freezer temperatures are recorded. All foods in fridges are date labelled. Temperatures are recorded on inwards goods. Kitchen equipment is serviced six monthly. Chemicals are stored safely. The kitchen is locked after hours. Cleaning schedules are maintained.  E 3.3f, ARHSS D15f: There is evidence that there is additional nutritious snacks available over 24 hours. Yoghurts, smoothies, biscuits, fruit and sandwiches are replenished daily in the kitchenette fridges. All foods sighted are dated. Facility fridges temperatures are monitored daily.  D 19.2 Staff have been trained in safe food handling. The head cook is the service educator. Four staff have recently completed the hospitality course. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The building has a current warrant of fitness that expires 22 June 2014. The previous shortfall of an annual building warrant of fitness has been addressed. Hot water temperatures are monitored monthly. There is evidence of corrective actions taken for unacceptable temperature readings.  E3.4d, ARHSS D15.3d. The lounge area is designed so that space and seating arrangements provide for individual and group activities. The nursing station is shared between the psychogeriatric unit and mental health unit that allows observation of all residents in the communal area. There is camera surveillance in the corridors and quiet lounges.  ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, roho cushions, shower chairs, lifting and standing hoists mobility aids, weighing scales and electric beds. Interviews with one RN and two caregivers from the PG unit confirmed there was adequate equipment.  E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required. There is a smaller quiet lounge in each area. All bedrooms are single.  E3.4c; ARHSS D15.3b: There are safe and secure outside areas for both areas that is easy to access safely.  The following DHB concerns have been addressed a) The kitchen in the dementia unit has been modified and in use and b) There is a generator available for use in the event of a power outage. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint policy (251) states the philosophy is 'we are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated".  There is a regional restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures  The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has four bedrail in use as enablers. There are ten residents using restraint in the form of bed rails and low beds. There is no restraint (including the four-figure hold previously used) in the mental health, psychogeriatric or rest home units. The two files reviewed of the residents with an enabler-included assessment, consent, interventions and three monthly evaluations. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level. |

##### **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:** 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 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous audit identified that not all incidents of emergency restraint were documented on incident forms or discussed at the restraint meeting did not include all incidents of emergency restraint. There has not been an incident of emergency restraint since March 2013 as confirmed in interviews with nine caregivers (three who work across all areas, three who work in the dementia unit and three who work in the mental health and psychogeriatric units), six registered nurses (three from the hospital, one who works in the rest home and dementia units and two who work in the mental health and psychogeriatric units, including the restraint coordinator), the clinical nurse manager and the facility manager. The emergency restraint used in March 2013 was documented on an incident form and restraint meeting minutes (as part of the quality meeting) show it was discussed in this meeting. The previous shortfall has been addressed. |

##### **Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)**

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

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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 8134.3:2008: 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:** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the manager’s report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP who advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.  Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. |

##### **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.)* |