Bupa Care Services NZ Limited - Rahiri Lifestyle care & Village

Current Status: 6 May 2014

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

General overview

Rahiri Lifestyle Care Home is part of the Bupa group having undergone a provisional audit in respect of a sale in May 2013. The service is certified to provide hospital (medical and geriatric), rest home and dementia level care for up to 49 residents.

Rahiri care home manager and clinical manager have been in the facility for a number of years. The manager has many years' experience in aged care and management. Staff turnover remains low. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Rahiri. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. With the exception of three rooms, all rooms in the hospital and rest home wings are of suitable size to accommodate hospital and rest home level residents.

There are six improvements required around corrective action plans, incident reporting, staffing, aspects of medication management and the resident activities programme, and hot water temperature management.

Audit Summary as at 6 May 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 6 May 2014

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

Organisational Management as at 6 May 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Continuum of Service Delivery as at 6 May 2014

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

Safe and Appropriate Environment as at 6 May 2014

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

Restraint Minimisation and Safe Practice as at 6 May 2014

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

Infection Prevention and Control as at 6 May 2014

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

Audit Results as at 6 May 2014

Consumer Rights

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

Organisational Management

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

Continuum of Service Delivery

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

confirmed the admission process and that the agreement was discussed with them. The residents' records reviewed shows the provider has implemented systems to assess, plan and evaluate care needs of the residents. Care plans are reviewed six monthly, or when there are changes in health status and the notes include input from the GP and allied health professionals. Medication policies and procedures are in place to guide practice. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around prn medication. The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. The programme is designed for high end and low end cognitive functions and caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis. There is an improvement required around the provision of activities in the dementia unit and the number of people accompanying van outings. All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

Safe and Appropriate Environment

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for hospital and rest home level residents, with the exception of three rest home only rooms. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff holds a current first aid certificate. The facility has central heating and temperature is comfortable and constant. There is an improvement required around water temperature management. The rooms audited are suitable to meet the needs of both rest home and hospital residents except for rooms 14, 15 and 16.

Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service currently has four residents in the hospital assessed as using a restraint. There are no enablers in use. A register for each restraint is completed that includes a three-monthly evaluation. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training and is supported by the Bupa quality and risk team. The

infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

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

Audit Report

Legal entity name:	Bupa Care Services NZ Limited
Certificate name:	Bupa Care Services NZ Limited - Rahiri Lifestyle Care & Village

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit
Premises audited:	Rahiri Lifestyle Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	**Start date:** 6 May 2014 **End date:** 7 May 2014

Proposed changes to current services (if any):
Assessment of rooms for ability to be ‘dual-purpose’ between hospital and rest home level

Total beds occupied across all premises included in the audit on the first day of the audit:	46

Audit Team

Lead Auditor	XXXXX	**Hours on site**	14.5	**Hours off site**	8
Other Auditors	XXXXX	**Total hours on site**	14.5	**Total hours off site**	8
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	29	Total audit hours off site	18	Total audit hours	47

Number of residents interviewed	6	Number of staff interviewed	16	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	53	Number of relatives interviewed	9
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Wednesday, 4 June 2014

Executive Summary of Audit

General Overview
Rahiri Lifestyle Care Home is part of the Bupa group having undergone a provisional audit in respect of a sale in May 2013. The service is certified to provide hospital (medical and geriatric), rest home and dementia level care for up to 49 residents. On the day of the audit there were 20 hospital residents, 18 rest home residents and eight residents in the dementia unit. Rahiri care home manager and clinical manager have been in the facility for a number of years. The manager has many years' experience in aged care and management. Staff turnover remains low. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Rahiri. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. With the exception of three rooms, all rooms in the hospital and rest home wings are of suitable size to accommodate hospital and rest home level residents. There are six improvements required around corrective action plans, incident reporting, staffing, aspects of medication management and the resident activities programme, and water temperature management.

Outcome 1.1: Consumer Rights
Rahiri endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

Outcome 1.2: Organisational Management
Rahiri is implementing the organisational quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Rahiri is benchmarked in three of these (hospital, rest home and dementia). There are two improvements required, one around corrective action close out and the second around incident reporting documentation. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There is an improvement required around staffing.

Outcome 1.3: Continuum of Service Delivery
The service has comprehensive admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The residents' records reviewed shows the provider has implemented systems to assess, plan and evaluate care needs of the residents. Care plans are reviewed six monthly, or when there are changes in health status and the notes include input from the GP and allied health professionals. Medication policies and procedures are in place to guide practice. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around prn medication. The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. The programme is designed for high end and low end cognitive functions and caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis. There is an improvement required around the provision of activities in the dementia unit and the number of people accompanying van outings. All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

Outcome 1.4: Safe and Appropriate Environment
Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for hospital and rest home level residents, with the exception of three rest home only rooms. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff holds a current first aid certificate. The facility has central heating and temperature is comfortable and constant. There is an improvement required around water temperature management. The rooms audited are suitable to meet the needs of both rest home and hospital residents except for rooms 14, 15 and 16.

Outcome 2: Restraint Minimisation and Safe Practice
There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service currently has four residents in the hospital assessed as using a restraint. There are no enablers in use. A register for each restraint is completed that includes a three-monthly evaluation. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Outcome 3: Infection Prevention and Control
The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training and is supported by the Bupa quality and risk team. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained

through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	44	0	6	0	0	0
Criteria	0	95	0	6	0	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	0
Criteria	0	0	0	0	0	0	0	0

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 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Four of 11 internal audit corrective action plans did not have the identified corrective actions signed as having been completed.	A process is established (and implemented) to document the close of corrective action plans resulting from internal audit activity.	180
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		appropriate their family/whānau of choice in an open manner.				
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Of 20 incident forms, 15 did not have relevant sign off. One of the incident forms related was traced back to the resident file and it was noted appropriate clinical care had been put in place, reviewed regularly and updated. Based on the information found, the risk is therefore considered low.	Establish and implement process to ensure incident forms are signed off by the care home manager as prescribed in policy.	30
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	There are times when the facility is reported (relative and staff interview) to have insufficient staff to meet the current resident needs.	Review staffing levels and resident acuity to ensure care needs are safely met.	30
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the	PA Low	i) There is no documented evidence that activities occur in the dementia unit on a regular basis. ii)	i) Ensure there is a day activity programme being consistently delivered in the dementia unit. ii) Ensure that all van trips have at least two	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		consumer.		Residents on van outings are only accompanied by the diversional therapist who is also the driver of the van. (The Bupa policy states two staff should go on outings.)	chaperones (a van driver and another person in the back with the residents).	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Eleven out of fourteen medication charts reviewed did not contain indications for the use of prn medication.	Ensure all PRN drugs have indications for the use of PRN medication.	60
HDS(C)S.2008	Standard 1.4.3: Toilet, Shower, And Bathing Facilities	Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	PA Low			
HDS(C)S.2008	Criterion 1.4.3.1	There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers	PA Low	The hot water temperatures have been recorded as high for the previous two months with temperatures recorded up to 50 and 60 degrees Celsius. The testing is carried out by a contractor who has not	Ensure there is a process for reporting high water temperatures and corrective actions are completed.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		or visitor use.		brought this to the attention of the manager		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: Bupa policies and procedures are being implemented and align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about the Code at orientation and at in-service training. Codes of Rights competency questionnaires are also completed. Interview with five caregivers (one dementia, four who work across the hospital and rest home) demonstrate an understanding of the Code. Resident rights/advocacy training was provided March 2014 (six attended). Residents interviewed (four rest home and two hospital) and relatives (seven hospital, one rest home and one dementia care) confirm staff respect privacy, and support residents in making choice where able.

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

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

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA
Evidence: There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Information is also given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Large print posters of the Code and advocacy information are displayed through the facility. The two monthly resident/family meetings also provide the opportunity for residents and family to raise issues/concerns (minutes sighted). Residents interviewed (four rest home and two hospital) and relatives (seven hospital, one rest home and one dementia) inform information has been provided around the Code. The care home manager has an open door policy for concerns or complaints. D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission. The care home manager and registered nurses described discussing the information pack with residents/relatives on admission. D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The confidentiality and resident privacy policy states the care home manager is the privacy officer (confirmed in interview). The policy includes confidentiality, privacy, collection of Information, storage of Information, and access to health information (disclosure). The personal objects of significance policy outline the process for the care of personal objects. A tour of the facility confirms there is the ability to support personal privacy for residents. During the audit, staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. Resident files are stored out of sight. A neglect and abuse policy (201) includes definitions and examples of abuse. Staff could describe definitions. Nine relatives interviewed stated that the care provided is overall very good and that staff are very caring. Abuse and neglect training was last delivered in March (10 staff attended). There are no complaints in those reviewed that related to disrespectful behaviour, and there is no evidence of abuse/neglect. A resident satisfaction survey was completed in November 2013 that resulted in a 92% overall satisfaction with the service – including 99% of respondents were satisfied that staff took the time to know residents, and 99% satisfied with the home like environment. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with five caregivers describe how choice is incorporated into resident cares. Interview with six residents (four rest home and two hospital) inform staff are respectful. There is an abuse and neglect policy that is being implemented and staff attend inservice education on abuse and neglect. Interviews with residents and family members were extremely positive about the care provided. E4.1a One relative (from the dementia unit) interviewed stated their family member was welcomed into the dementia unit and personal items were evident in rooms to make it more familiar to the resident. D4.1a Seven resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family

involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with six residents confirm their values and beliefs were considered. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files

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

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

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

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

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

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

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

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

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

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

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

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

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

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA
Evidence: A3.2 Bupa has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori.

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff report there are no residents that identify as Maori, however there is one resident who lives by Maori beliefs who reported her cultural values are adhered to. D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa's facilities. The ADHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. The service has an attachment to the policy that relates specifically to the area. Local Iwi and contact details of tangata whenua are identified. Special events and occasions are celebrated and this could be described by staff.

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: An initial care planning meeting six weeks after admission is carried out, where the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with nine relatives inform values and beliefs are considered. Discussion with six residents (four rest home, two hospital) confirm that staff take into account their culture and values. D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau. D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: The Code of Conduct is included in the Employee Pack. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. The enrolled nurses (two interviewed) work under the direction and supervision of the registered nurses (RN)'s. There is policy to guide staff practice: Gift, Gratitude's and Benefits, Delegations of Authority. Clinical meetings occur two monthly (held with registered staff) and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the clinical manager, two registered nurses and two enrolled nurses confirm an awareness of professional boundaries.

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

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

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. This group meets every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. The Bupa geriatrician provides newsletters to GPs.
Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services and Rahiri is benchmarked three areas (hospital, rest home and dementia). Graphs and data is provided to staff on the noticeboard and corrective actions completed when trends are evident or areas are above the benchmark, for example two corrective action plans were sighted relating to falls that were above the benchmark. Actions were reviewed and signed out.
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. Bupa has robust quality and risk management systems and these are being implemented at Rahiri (link 1.2.3 and 1.2.4) supported by a number of meetings held on a regular basis.
ARC A2.2 Services are provided at Rahiri that adhere to the health & disability services standards. There is an established quality improvement programmes that includes performance monitoring (link improvements identified in 1.2.3 and 1.2.4). ARC D1.3 all approved service standards are adhered to.

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

There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.
Bupa has a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). This is in the process of being implemented at Rahiri. The Personal Best facilitator reports two staff at gold, between 5-10 at silver and 10-15 at bronze.

Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation. The service has introduced leadership development of qualified staff - education from HR, attendance at external education and Bupa qualified nurses' education day and education session at monthly meeting.
ARC D17.7c There is implemented competencies for caregivers, enrolled nurses and registered nurses. Standardised annual education programme, core competency assessments and orientation programmes are being implemented at Rahiri. Competencies are completed for key nursing skills at Rahiri

including (but not limited to); a) moving & handling, b) wound care, c) sub cut fluids, d) assessment tools and e) medication. RNs have access to external training.
Discussions with residents (four rest home, two hospital) and relatives (one rest home, seven hospital, one dementia) were positive about the care they receive.
Rahiri underwent a provisional audit in respect of a sale (Oceania to Bupa) in May 2013 and has been working to implement Bupa processes since that time. The staff remain stable having worked at the facility for extended periods of time. The care home manager and clinical manager have both been in position for some time.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Accident/incident, category ones (i.e., major resident incidents), complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is a specific policy to guide staff on the process to ensure full and frank open disclosure is available. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. 27 incident forms reviewed from across 2014 (all service types) identified that family were notified following a resident incident. Incident/accident forms are audited as part of the internal auditing system and a criterion is identified around "incident forms" informing family. The audit was completed in April (2014) confirmed family notification. A residents/relatives association was initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician.

At an organisational level, a residents/relatives association provides a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. Newsletters were in place at Rahiri.
Interpreter policy and contact details of interpreters. A list of Language Lines and Government Agencies is available. .
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b: Nine relatives (seven hospital, one rest home and one dementia) stated that they are informed when their family members health status changes.
D11.3: The information pack is available in large print and this can be read to residents.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the care home manager, the administrator and the clinical manager confirm practice is consistent with policy. Interviews with six residents (two hospital and four rest) confirm that they are aware of their right to access advocacy. D4.1d; Discussions with nine family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions ARC D4.1e. The resident files include information on residents' family/whanau and chosen social networks.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: D3.1h: Interview with six residents and nine relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping (link 1.3.7). Residents are assisted to meet

responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with six residents confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.
D3.1.e: Discussion with five caregivers, the activities coordinator, nine relatives and six residents confirm that residents are supported and encouraged to remain involved in the community and external groups (link 1.3.7).

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The complaints procedure (065) states 'The Care Home Manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint management record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. 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 also around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with six residents and nine relatives confirm they were provided with information on. Complaint forms were visible for residents/relatives in various places around the facility. There are a small number of complaints – four between July and December 2013, and one between January and May 2014. All are well documented including investigation, follow up and resolution. D13.3h. a complaints procedure is provided to residents within the information pack at entry

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Rahiri 2014 quality goals included preparation for this certification audit and dementia training for staff working in the unit. Interview with the care home manager informs sound progress is being made toward the latter. Progress towards the goals is seen in quality meeting minutes.

Bupa Rahiri provides care for up to 49 residents across three service levels (rest home, dementia and hospital). On the day of audit there were 18 of 20 rest home residents, eight of eight residents in the dementia unit and 20 of 21 hospital residents. There are no residents under the medical component at the time of audit. This audit considered all rest home and hospital beds for suitability for either hospital or rest home level residents. This audit confirmed that with the exception of rooms 14, 15 and 16, all rooms are of suitable size for both levels of care.

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. In 2009, Bupa introduced a person centred care focus which includes six pillars. This has being embedded in service delivery at Rahiri. The organisation has commenced a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) will also be tabled at this forum.

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 has commenced.

Rahiri is part of the central Bupa region which includes ten facilities. The managers in the region meet three times a year. A forum is held every six months (with national conference) including all the Bupa managers. Rahiri annual goals link to the organisations goals and this is reviewed in quality meetings and followed through in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'.

Rahiri is implementing the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care including - knowledgeable staff / meaningful activities / comfortable environment. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans have been implemented since Bupa purchased Rahiri. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care.

The Bupa CNS 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. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care.

The service is managed by an experienced registered nurse who has been the care home manager at Rahiri for four years. She has an extensive background in Aged Residential Care and is supported by a clinical manager who has been in this position for approximately three years. Support is also provided by the operations manager who visits at least once each month.
Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

Attainment and Risk: FA
Evidence: During a temporary absence, the clinical manager, Bupa relief manager or operations manager will cover the manager's role. The operations manager provides oversight and support. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Rahiri is implementing the Bupa quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with associated clinical forms. 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 meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule. Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all clinical/Care Home Managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the quality committee at Rahiri who meet bimonthly. Weekly reports by care home manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home, dementia unit and hospital services, and staff incidents/accidents (link improvement identified 1.2.4.3).
The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints.
The Rahiri infection control committee meet bimonthly and the weekly reports from the care home manager cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee.
Health and safety committee meets monthly and is also an agenda item at the quality committee with feedback going to staff meetings.
Rahiri is implementing the Bupa quality and risk management process. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Rahiri via graphs and benchmarking reports. An improvement is required around ensuring corrective actions identified as part of the internal audit activity are closed out on the corrective action plan.
The care home 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 / H&S staff indicators and the like throughout the year.
Benchmarking of 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 key indicators with another NZ provider has commenced. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are being adopted at Rahiri and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans (link 1.2.3.8) and responsibilities for corrective actions are identified.

D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has an H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury. On-going review of objectives for Rahiri is seen in H&S meeting minutes.
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:	
Timeframe (days):	*(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.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

Attainment and Risk: PA Low
Evidence: Rahiri is implementing the Bupa quality and risk management process including the internal audit schedule. The internal audits completed between January and May (2014) were reviewed and audit summaries and action plans (including naming a responsible staff member) are completed where a noncompliance is identified. Four of the 11 internal audit corrective action plans recorded for the period above did not have the identified corrective actions signed as having been completed. Interview with the care home manager confirmed the recorded actions are either underway or completed. While document closure of corrective action plans for the internal audit programme is inconsistent, there were examples of documented close out of corrective actions resulting from other activity – for example against the findings from the provisional audit – and as there was evidence of progressing corrective actions from internal audit, this finding is considered to be of low risk. Internal audit results are reported to the appropriate committee and discussed at staff meetings (minutes sighted, and interview with five caregivers and two enrolled nurses). Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Rahiri via graphs and benchmarking reports.
Finding: Four of 11 internal audit corrective action plans did not have the identified corrective actions signed as having been completed.
Corrective Action: A process is established (and implemented) to document the close of corrective action plans resulting from internal audit activity.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

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

Attainment and Risk: PA Low
Evidence: D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The competed form is forwarded to the quality and risk team as soon as possible (definitely within 24 hours of the event), even if an investigation is on-going. Incident forms reviewed for January 2014 (to date) with a focus on the 20 forms written for the month of April. Of the 20 forms, 15 identified there had been no care home manager sign off. D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark including (but not limited to); falls in both November 2013 and March 2014. Corrective action plans were completed and signed off. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with an area to document immediate action and any follow up action required. This was confirmed during interview with five caregivers and two enrolled nurses. Incident data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were sighted for incidents above the benchmark including (but not limited to); falls in November 2013 and March 2014. Corrective action plans were completed and signed off. The incident reports for April (2014) were reviewed and of the 20 completed forms, 15 did not have care home manager sign off in the manner prescribed in policy. In addition six of the 15 did not have care home manager sign off at all. One of the incident forms related to a sacral pressure area. This was traced back to the resident file and it was noted a short term care plan had been completed, reviewed regularly and updated. The resident notes also reflected the care provided. The care home manager explained the current process which confirmed the issue relates to the process rather than clinical care. Based on the information found, the risk is therefore considered low
Finding: Of 20 incident forms, 15 did not have relevant sign off. One of the incident forms related was traced back to the resident file and it was noted appropriate clinical care had been put in place, reviewed regularly and updated. Based on the information found, the risk is therefore considered low.
Corrective Action: Establish and implement process to ensure incident forms are signed off by the care home manager as prescribed in policy.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA

Evidence:

Register of registered nurse (RN) and enrolled nurse (EN) practising certificates is maintained, both at facility level and 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 including recruitment, selection, orientation and staff training and development. Ten files reviewed files (clinical manager, two registered nurses, four caregivers, cook, diversional therapist, team leader laundry & cleaning) and all had personal file checklists. Performance appraisals are current in all files reviewed.
The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time. Staff interviewed (five caregivers, two registered nurses, two enrolled nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interview with the clinical manager confirmed 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. There is an RN/EN training day provided through Bupa that covers clinical aspects of care - eg. Wound management. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN 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 is aware of the requirement to complete competency training.
Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses.
There is a staff member with a current First Aid Certificate on every shift, and the refresher was provided in January (2014) where 12 staff attended.

E4.5f All staff working in the Dementia wing hold qualifications or are completing the Dementia Qualifications through Career Force. The last three are in the process of completing their final module.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

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

There is an RN and first aid trained member of staff on every shift. The service also has experienced enrolled nurses. Interviews with five caregivers inform the RN's and EN's are supportive and approachable. There are a variety of shift hours through the am and pm and on night duty there is 1x RN and 3x caregivers across the facility. There is a qualified diversional therapist at the facility with additional recreation hours allocated to the dementia unit (link 1.3.7).

While the reviewed roster appears to meet contractual requirements for staffing, there were a number of factors observed during the audit that would suggest there are times the facility is under pressure to safely meet the care needs of the residents including: the facility is large and care services are spread out, a resident in the dementia unit who reportedly requires three staff to complete personal cares (the resident is being assessed for

psychogeriatric care) which essentially leaves the remaining residents unsupervised, the hospital lounge was observed to be unsupervised for periods of time during the audit, this was supported by interview with three (of nine) relatives. Staff interviews informed there has recently been some reduction in hours which is adding pressure to the workload. Based on the evidence during the audit staffing allocation should be reviewed.

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

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

Attainment and Risk: PA Low

Evidence:

The roster was reviewed and there was no evidence to suggest staffing levels did not meet contractual requirements. There is an RN across all shifts, an experienced EN workforce and committed caregivers. There appears to sufficient numbers of auxiliary staff – kitchen, cleaning, laundry, activities (link 1.3.7). There are a number of 'split-shifts' being rostered, and it is noted the care staff reported finding these shifts difficult to maintain.

However during the audit the following was noted:
a) In the dementia unit there are periods of time where one caregiver is working alone – i.e. between 1300 to 1700. During the audit a lack of activities in the dementia unit was observed (link 1.3.7), and one resident is being assessed for psychogeriatric care. This resident reportedly requires three caregivers to assist with personal cares and a caregiver is pulled across from the rest home. During this time the remaining residents are essentially unsupervised.
b) The hospital wing has two spacious lounges. On day 1 of the audit the lounge was observed to be unsupervised for a period of time, during this time a resident who was in a restraint was observed to be restless, trying to stand and reportedly wanted the toilet. Relative interview informed there are times when this lounge does not have staff. Due to the facility layout, it took some time to locate a staff member to assist the resident – also refer evidence against 1.4.7.
c) Further interviews with relatives informed there are occasions when there is 'insufficient' staff; this was across all service areas.
d) Staff interviews inform recent reduction in some shift hours which has reportedly increased the pressure on completing allocated 'tasks'.

Finding:

There are times when the facility is reported (relative and staff interview) to have insufficient staff to meet the current resident needs.

Corrective Action:

Review staffing levels and resident acuity to ensure care needs are safely met.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

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

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

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

Attainment and Risk: FA

Evidence:

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service.
Information gathered at admission is retained in resident's records. Six residents interviewed (two from the hospital and four from the rest home) and nine family/whanau (one from the rest home, one from dementia and seven from the hospital) stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the health and disability Code of Rights, how to access advocacy and the health practitioners code. The service assesses needs on entry of a resident to the service. This includes identification of risks. Residents and family/whanau members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.
D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.
D14.1: Exclusions from the service are included in the admission agreement.
D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
E4.1.b: There is written information on the service philosophy and practices. Included in the information pack is dementia specific documentation for those entering the dementia unit. Information involves (but is not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:
1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.
E3.1: Two resident files were reviewed in the dementia unit and both included a needs assessment as requiring specialist dementia care.

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

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

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

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

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA
Evidence: There are records kept of reason for any declined entry; due to there being no beds available or else the unavailability of required level of care. On interview management were able to discuss the process of declined entry and support and alternatives for those declined.

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an admission – role of caregiver policy, an admission – role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.
In seven of seven files sampled (two from the rest home, three from the hospital and two from the dementia unit) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a RN. Medical assessments are completed on admission by the GP in seven of seven files sampled and six monthly multi-disciplinary reviews are completed by the RN with input from caregivers, the GP, the activities coordinator and any other relevant person. Activity assessments and the activities sections care plans have been completed by an activities coordinator.
Six residents interviewed (four from the rest home, two from the hospital) stated that they and their family/whanau were involved in planning their care plan on admission and again on evaluation. Resident files included family contact records which were completed and up to date in all seven resident files sampled.
D16.2, 3, 4: The seven files reviewed (two from the rest home, two from the dementia, and three from the hospital), identified that in all seven files an assessment was completed within 24 hours and all seven files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by a RN and amended when current health changes. All seven care plans evidenced evaluations completed at least six monthly.
D16.5e: All seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.
A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment. Caregiving staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. All seven files identified integration of allied health and a team approach is evident in the seven files. The XXXXX Medical Centre and Dr XXXXXXXX (private practice) provide the main GP services. The GP interviewed spoke positively about the service and that care is delivered in a timely manner. Physiotherapy assessment and occupational therapy assessments occur as necessary.

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

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

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

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

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

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

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

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa Rahiri has implemented the Bupa assessment booklets and care plan templates for all residents. The assessment booklet provides very in-depth assessment tools including; falls, Braden, skin, mini nutritional, continence, pain, dependency and activities. The falls assessment section also includes additional risk factors, for example; vision, mobility, behaviours, environment and continence. Risk assessment tools and monitoring forms are reviewed at least six monthly and are used to effectively assess level of risk and required support for residents including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, MNA, incontinence assessment, behaviour assessment, pain assessment, skin assessment, dependency rating and wound assessment. The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information.
Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse. Seven of seven files sampled (two from the rest home, two from dementia and three from the hospital) contain assessments including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, skin assessment, MNA, incontinence assessment, behaviour assessment, and wound assessment (where appropriate). Assessments and support plans are comprehensive and include input from allied health. The assessment booklet includes input from team members. Notes by GP and allied health professionals are evident in resident's files, significant events, communication with families and notes as required by registered nurses. Families/whanau interviewed are supportive of the care provided and express that the needs of their family member are being met.
ARC E4.2; D16.2; All seven resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.
E4.2a: Challenging behaviour triggers and de-escalation techniques are included into the support plan.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The sample of files reviewed included; two dementia resident files, three hospital files and two rest home resident files. Service delivery plans overall demonstrate service integration and input from allied health professionals. All short term and long term care plans reviewed were completed or signed off by a RN. Notes by GP and allied health professionals, significant events and communication with families. The long-term care plan is completed within three weeks with GP involvement within 48 hours. Plans are well described and are reflected in the progress notes. The seven residents' care plans reviewed (two dementia, three hospital and two rest home) provide evidence of individualised support and intervention required. The six residents interviewed (four rest home and two hospital) and nine families/whanau interviewed (one in the rest home, seven hospital and one from the dementia unit) confirm care delivery and support by staff is consistent with their expectations. E4.3: Two resident files (from dementia) reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. D16.3k: Short term care plans are in use for changes in health status. D16.3f; Resident files reviewed identified that family/whanau were involved.

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: FA
Evidence: Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers or enrolled nurses on each shift in the hospital and each 24 hours in the rest home (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the

registered nurse initiates a review and if required, GP or specialist consultation. The five caregivers, two enrolled nurses and two registered nurses interviewed 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 (two hospital and four rest home) and nine families/whanau interviewed (seven from the hospital, one from dementia and one from the rest home) were complimentary of care received at the facility. The care being provided is consistent with the needs of residents; this is evidenced by discussions with five caregivers, two enrolled nurses and nine families. There is a short-term care plan that is used for acute or short-term changes in health status
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 five residents (one boil, two skin tears, one chronic wound area, one surgical wound, two chronic leg ulcers and one Grade1pressure area). The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. There is evidence of the wound district nurses being previously involved in the care of one wound. The facility has registered nurse cover 24/7 and has an 'in service' education programme. A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by an RN. Care plans are goal oriented and reviewed six monthly for all files. During the tour of facility, it was noted that all staff treated residents with respect and dignity, residents and families/whanau 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.

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

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

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

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

Attainment and Risk: PA Low

Evidence:

There are is one diversional therapist who is employed Monday to Friday 9am to 4pm to provide the activities programme for hospital and rest home residents. The programme in the dementia unit is run by a caregiver under the supervision of the diversional therapist. The caregiver is employed specifically for an additional two hours a week for the purpose of planning, coordinating and documenting the programme for the residents living in the dementia unit. The caregivers who are employed to provide care within the dementia unit are responsible for the delivery of the activities programme. There is a 24 hour wheel in operation that alters depending on the resident's moods in the dementia unit and the programme includes doing household activities. Residents in the dementia unit are able to participate in the rest home activities programme from time to time and participation is dependent on their mood and behaviour and the availability of staff to provide supervision. The dementia unit programme includes activities related to normal daily living (eg setting the dining room table, clearing dishes, folding some laundry, cooking (icing biscuits)),and other group and individual activities (eg, walks 1:1) housie, exercises, hairdressing, manicures, newspaper reading, visits by external entertainers, sports games (eg quoits, balloon tennis, ball catching). On the one and a half day audit it was observed that there was no evidence that recreational activities were being provided within the dementia unit on a regular basis as per the programme. The unit was checked during the morning and afternoon periods. It was observed that residents were sitting in the lounge unoccupied or wandering throughout the unit. There was only one staff member on duty in the unit at these times. On interview the family/whanau, caregivers, diversional therapist, enrolled nurses and registered nurses all confirmed that recreational activities were not delivered consistently as there was not enough staff to manage (link 1.2.8). This is an area requiring Improvement.

All three programmes include group and individual activities. Programmes are developed monthly and displayed in large A3 size print in the dementia unit. The programme is displayed on white boards for the rest home and hospital residents. The hospital level programme includes but is not limited to: activities such as music, hairdressing, wheelchair walks, stories and group discussions, massage, pet therapy, van rides, newspaper readings, DVDs, external visitors. The rest home activities programme includes but is not limited to: physical activities (eg, exercises, bowls, skittles, walks); music, reminiscing, pet therapy, housie, happy hours, cards, bingo, piano playing, spelling quests, DVDs, CD music, manicures, hairdressing, current affairs discussions. Staff matches the programme to the health of the residents and their preferences/preferred choices. Different church denominations take it in turns to come each Sunday afternoon following their morning services. On the day of audit residents in all the hospital and rest home areas were observed being actively involved with a variety of activities both group and individual. Some residents choose to do activities in their own rooms.

All residents have an initial social and activities assessment within three weeks of admission in keeping with the Bupa recreation activities programme policy. Assessments are completed by the diversional therapist and or the caregiver (if the resident is living in the dementia unit). The assessment includes a complete history of past and present interests, career, and family relationships. Individual plans are developed for the resident and documented and integrated within the resident's care plan. Activities attended by the resident are then recorded in a monthly attendance record. A summary of the resident's involvement in activities is recorded within the progress notes. The effectiveness of the plan is evaluated six monthly at the multi-disciplinary care plan review (sighted).

On the following four van outings - 20.3.14 (nine residents), 27.04.14 (seven residents), 30.04.14 (seven residents) and 01.05.14 (seven residents including two hospital residents and one dementia resident) were accompanied by the diversional therapist who was the driver of the van. On one occasion a resident undid the seat belt and stood up (incident report sighted). The staff interviewed confirmed that often the residents on outings are only

accompanied by one person. This requires improvement.

All six residents (four rest home, and two hospital) and eight relatives/whanau (one rest home, seven hospital) stated they were happy with the activities programmes and that people were given choices regarding participation.
D16.5d: Each resident has a written and implemented social and recreational programme which is reviewed when the long term care plan is reviewed.

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

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

Attainment and Risk: PA Low

Evidence:

There are is one diversional therapist who is employed Monday to Friday 9 am to 4.pm to provide the activities programme for hospital and rest home residents. The programme in the dementia unit is run by a caregiver under the supervision of the diversional therapist. There are three group activities programmes in operation as well as individualised activities.

Finding:

i) There is no documented evidence that activities occur in the dementia unit on a regular basis. ii) Residents on van outings are only accompanied by the diversional therapist who is also the driver of the van. (The Bupa policy states two staff should go on outings.)

Corrective Action:

i) Ensure there is a day activity programme being consistently delivered in the dementia unit. ii) Ensure that all van trips have at least two chaperones (a van driver and another person in the back with the residents).

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

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

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

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

Attainment and Risk: FA

Evidence:

Care plans are reviewed and evaluated by the RN at least six monthly or when changes to care occur as sighted in seven of seven care plans sampled. On interview the diversional therapist was able to discuss her part in care planning evaluations. There is also documentation evidence of family/whanau and/or resident involvement at these evaluations. On interview nine relatives/whanau confirmed that they were invited to attend care-planning review meetings. Documentation on clinical notes evidence review by the GP at least three monthly. There are short term care plans to focus on acute and short-term issues. Changes to the long-term care plan are made as required and at the six monthly reviews if required. From the sample group of residents' notes the short-term care plans are well used and comprehensive. Examples of short-term plan use included; infections, wounds and unexplained weight

loss. D16.4a: Care plans are evaluated six monthly and more frequently when clinically indicated. ARC: D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

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

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

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

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

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

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

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

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

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

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

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

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: There is a transfer plan policy. A record is kept and a copy is kept on the resident's file. This was sighted in one resident file (from the rest home) where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service.

A transfer form accompanies residents to the receiving facilities. Follow up occurs to check that the resident is settled in hospital, or in the case of death, communication with the family/whanau is made. Caregivers, enrolled nurses, registered nurses and the clinical manager were able to discuss the process of transfer.

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Medication management policies and procedures cover each stage of safe administration of medicines including, delivery, storage, medicine reconciliation and returns. The pharmacy supply medico blister pack medications and other pharmaceuticals to the facility. Two RN's check medications on delivery and report any discrepancies to the pharmacy. The controlled drugs (CD's) are stored in a locked safe in a locked cupboard in the hospital treatment room. The room is locked at all times. A weekly stocktake of CD's is carried out by two registered nurses (sighted). Each unit has a locked area where the medication trolley is stored. Medications in all the trolleys including GTN sprays, ointments and eye drops had not expired and are dated when opened. There are medication fridges in the hospital and rest home units. Both fridges are monitored daily and temperatures are within acceptable ranges. The dementia unit staff have access to the rest home fridge. All returns to the pharmacy are held in the hospital medication room and records kept of returns. There are approved biohazard containers available for the safe disposal of sharps. The medication folders include a list of specimen signatures, instructions for the treatment and management of hypoglycaemia and resident pain assessment forms where applicable. All medication competent staff are responsible for medication administration in all areas. All caregivers and RN's undergo annual medication competencies (sighted). Medication management education was provided March 2014. RN's attend annual syringe driver education and competency sessions provided at Arohanui Hospice in Palmerston North last attended May 2013 and the next is booked for July 2014. Medication charts have photo ID's. There are

special instructions for administration or precautions if applicable with the resident drug chart. There are 'alert', allergy and duplicate name stickers used where required. Administration signing sheets for regular and prn medications given are signed correctly. Controlled drugs given are signed by two medication competent staff. Currently the service has no residents self-administering medications. Eleven out of 14 medication charts reviewed did not contain indications for the use of PRN medication. This is an area requiring improvement. The clinical manager states that she has brought this to the attention of the GP concerned. It is noted that the PRN medications charted by this GP, in the last month, have been charted correctly.
D16.5.e.i.2; Fourteen medication charts (four dementia, six hospital and four rest home) were sampled. All fourteen charts identified that the GP had reviewed and signed the medication chart at least three monthly.

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

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

Attainment and Risk: PA Low

Evidence:

Medication management policies and procedures cover each stage of safe administration of medicines including, delivery, storage, medicine reconciliation and returns. The pharmacy supply medico blister pack medications and other pharmaceuticals to the facility. Two RN's check medications on delivery and report any discrepancies to the pharmacy. The controlled drugs (CD's) are stored in a locked safe in a locked cupboard in the hospital treatment room. The room is locked at all times. A weekly stocktake of CD's is carried out by two registered nurses (sighted). Each unit has a locked area where the medication trolley is stored. All medication competent staff are responsible for medication administration in all areas.

Finding:

Eleven out of fourteen medication charts reviewed did not contain indications for the use of prn medication.

Corrective Action:

Ensure all PRN drugs have indications for the use of PRN medication.

Timeframe (days): 60 *(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.

Attainment and Risk: FA

Evidence:

Finding:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The national menus have been audited and approved by an external dietitian. The service employs two cooks and two kitchen hands. All meals are prepared on site from one central kitchen. There are kitchenettes in dining/lounge areas, including the dementia unit. All of the kitchen staff have completed food safety certificates. The service has a large workable kitchen that contains storeage cupboards, freezer, domestic fridge,a walk- in chiller, commercial oven and hot plates. There is a preparation area and receiving area. Kitchen fridge, food, dishwasher and freezer temperatures are monitored and documented daily. Resident annual satisfaction survey includes food services and there is also a post admission survey conducted after six weeks. There are a number of internal audits completed including; a) weight monitoring (February 2014) and b) Environmental hygiene - kitchen (February 2014) – link 1.2.3.8. There is a nutrition - assessment and management policy and a weight management policy.

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook that was interviewed. Special diets are noted in a book held in the kitchen out of view. Special diets being catered for include soft diets, high calorie meals, pureed meals and diabetic diets. In service education on diabetic management was held in February 2014. Weight management audit was completed in February (2014) with 93% compliance.

There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety. Hats and gloves are worn routinely in the kitchen. Bupa Care Homes introduced in 2010 a comprehensive food services programme that specifically targeted all areas of the food service as a quality improvement initiative throughout the business. This was in response to further improving on client satisfaction results with the service as identified through resident/relative satisfaction surveys. Achievements of the programme which continues in 2012 include the introduction of a steering group, monthly teleconferences with the chefs/cooks employed in each home, development of Bupa's own Recipes and Library of these and the review and update of all kitchen policies and procedures. Other activities included the development of "assisted eating posters" which includes a "Masterchef" DVD with Annabelle White, a dementia specific focus included emphasis on use of coloured crockery and suitable tasty finger foods and a streamline national food contract supply for meat, groceries and vegetables. The programme also developed food safety training powerpoints to augment the internal core education programme within care homes. A senior chef within the business provides support and mentorship to the cooks in each of the homes and following the pilot of a training programme for staff, Bupa kitchen staff complete unit standard 167 Food safety training. "Showing we care on a plate" was the title/catch phrase for the programme. This was described by the cook on interview.
Residents interviewed stated they were happy with the food service. The nine relatives interviewed were also were complimentary of the food provided. Observation of meal time (lunch) evidenced staff assisting residents as required.
E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

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

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

Attainment and Risk: FA
Evidence: Chemical/substance safety policy (048). There are policies on the following: - waste disposal policy. - Medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled food, broken glass or crockery, tins, cartons, paper and plastics. Procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff. The chemical safety audit in March 2014 found 100% compliance. All chemicals are clearly labelled with manufacturers labels. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Maintenance is currently being carried out by contractors. The Care Home Manager, the administrator or the team leader of household services organises for servicing to occur. Reactive and preventative maintenance occurs (programme documentation sighted). Maintenance requests are recorded in a log system and requests are signed off when actions have been completed. The building has a current warrant of fitness which expires 21-Jan-15. Electrical equipment is checked annually last completed July 2013. Fire equipment is checked by an external contractor. Hoists and medical equipment are checked, serviced and or calibrated. The living areas are carpeted. Vinyl surfaces exist in bathrooms/toilets and kitchen areas. The dementia unit has a mix of cork and linoleum flooring and one bedroom has carpet squares. The flooring in the main living area is vinyl. Resident rooms in the hospital and rest home areas are carpeted with vinyl in ensuites. The Hospital area has six bedrooms with ensuites. There are four bedrooms in the rest home with ensuites. There are no ensuite bedrooms in the dementia unit. There are two lounges in the hospital area, one lounge plus a bowls room in the rest home area and one lounge in the dementia area. There are separate dining rooms for each area. The facility has multiple numbers of toilets and showers and separate toilets for staff and visitors. The facility is fully equipped with electric beds in all hospital rooms and a number of individual rest home residents have these depending on their individual requirements. The corridors are carpeted and equipped with hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens are attractive with plenty of setting and shade. Residents in the dementia unit have a secure external area to wander in which includes a bird aviary. There is a range of outdoor furniture and a shade sail and umbrellas for providing shade. There is wheelchair access to all areas. Interviews with the clinical manager, two registered nurses, two enrolled

nurses and five caregivers confirmed there was adequate equipment.
All rooms audited except rooms 14, 15 and 16 (rest home) are assessed as satisfactory to meet the needs of rest home and hospital residents.
ARC D15.3; A range of equipment is available including but not limited to: pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids and weighing scales.
E3.3e: There is one lounge/dining area in the dementia unit. Resident's rooms provide privacy when required.
E3.4c: There is a safe and secure outside area that is easy to access for residents in the dementia unit.
E3.4: The lounge area in the dementia unit is designed so that space and seating arrangements provide for individual and group activities.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: PA Low
Evidence: The facility has five wings and one wing in the dementia area. There are showers and toilets throughout the facility. All resident rooms share communal facilities except for 10 rooms that have en-suites (i.e., six in the hospital area and four bedrooms in the rest home area). The rooms audited are large enough to meet the needs of both hospital and rest home residents. There are adequate visitor and staff toilet facilities with appropriate hand drying facilities available. Communal toilets and bathrooms have appropriate signage and easy access locks. Hot water temperatures are monitored. The hot water temperatures have been recorded as high for the previous two months with temperatures recorded up to 50 and 60 degrees Celsius. The testing is carried out by a contractor who has not brought this to the attention of the manager. This is an area requiring improvement. Corrective actions were put in place on the day of audit. Privacy is maintained at all times for residents (confirmed by observation and in discussion with six of six residents (two hospital, and four rest home) and nine of nine relatives/whanau (one rest home, one dementia and seven hospital). Fixtures and fittings are appropriate and fit for purpose.

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

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

Attainment and Risk: PA Low
Evidence: The facility has five wings and one wing in the dementia area. There are showers and toilets throughout the facility. All resident rooms share communal facilities except for 10 rooms that have en-suites. Communal toilets and bathrooms have appropriate signage and easy access locks. Hot water monitoring is carried out.
Finding: The hot water temperatures have been recorded as high for the previous two months with temperatures recorded up to 50 and 60 degrees Celsius. The testing is carried out by a contractor who has not brought this to the attention of the manager
Corrective Action: Ensure there is a process for reporting high water temperatures and corrective actions are completed.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: The rooms are spacious it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Five caregivers and two enrolled nurses from across each area report that rooms have sufficient rooms to allow cares to take place. All rooms audited except rooms 14, 15 and 16 (rest home) are assessed as satisfactory to meet the needs of rest home and hospital residents

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

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

Attainment and Risk: FA
Evidence:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA	
Evidence: Communal areas are available for relaxation, dinning and for entertainment. The rest home has a large main lounge and a smaller bowls room (complete with raised indoor bowling area) and a dining room. The hospital area has two lounges with one doubling as a dining area. The dementia unit has a combined lounge/dining area. All lounges and dining rooms are easy to access and can accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and six of six residents interviewed report they can move around the facility and staff assist them if required. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander in the dementia unit.	

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed six monthly (last one January 2014). An environmental hygiene - cleaning audit was last completed in March 2014 and scored 95.8%. Corrective actions required are followed through the quality/risk management and staff meetings (link 1.2.3.8). The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room . All chemicals are labelled with manufacturer's labels. There is sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Six residents, and nine relatives interviewed confirm the facility was kept clean.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety was last held in February 2013. Fire evacuations are held six monthly and the last drill was 26 November 3013. The next is scheduled for late May. There is staff across 24/7 with a current first aid certificate. There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage area outside; this includes an up to date register of all residents details. There is an approved evacuation plan (letter dated April 2007). The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits. Hoists have battery back up. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner (link 1.2.8.1). A test of a resident call bell (rest home) showed a response of less than one minutes. There are two lounges in the hospital wing, and it was noted the call bells in both areas are 'emergency' call only. Inteview with staff inform if they require routine assistance when in these lounge areas, they have to leave the lounge to find a colleague. This is noted to have been followed up by the Operations Manager during the audit and corrective action was being implemented. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

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

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

Attainment and Risk: FA
Evidence:

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)
Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: The facility has plenty of natural light in communal areas and plenty of natural light through external windows in each bedroom. Heating is a mix of electric panel heaters and radiators. Ventilation is managed by opening windows and doors. Facility temperatures are monitored by staff. The Care Home

Manager reported that the heating is able to be adjusted as to the season and individual resident need. There is an external area designated for residents who smoke and a separate smoking area for staff off the staff room. Six residents interviewed stated the temperature of the facility was comfortable.

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: Restraint policy (251) states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however, we acknowledge that there may be occasions when a resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated There is a Regional Restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service remains has four restraints and no enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level. Training and competencies have been completed by staff.

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

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

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: Only staff that have completed a restraint competency assessment are permitted to apply restraints. All staff restraint competency assessments have been completed at the time of audit. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisational level and at a service level. Interview with the restraint coordinator and review of her signed job description identifies her understanding of the role.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Four restraint files were reviewed (hospital level). All residents' files included completed assessments that considered those listed in 2.2.2.1 (a) - (h). In house restraint training was completed April 2014. A registered nurse is the restraint coordinator. A job description in place and is signed and dated.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

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

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails, lap belts). The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plans identifies the specific interventions or strategies to try (as appropriate) before implementing restraint. Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or family/whanau and the facility restraint coordinator. Restraint use is reviewed monthly during the facility restraint meetings and also as part of the three-monthly restraint reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions are initiated. The restraint coordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented. The resident's file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed in four hospital residents' files with restraint identified observations and monitoring as per their monitoring schedules. Restraint use is reviewed through the three monthly assessment evaluation, monthly restraint meetings and six-monthly multi-disciplinary meetings and includes family/whanau input. A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraint.

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.

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

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

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

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families/whanau are included as part of this review. A review of four of four files of residents using restraints identified that evaluations are up-to-date and have reviewed (but not limited to); whether the desired outcome was achieved, whether the restraint was the least restrictive option and the impact of the use of restraint. Restraint is evaluated on a formal basis monthly at the facility restraint meeting and three-monthly and six monthly by the regional restraint team. Evaluation timeframes are predetermined by risk levels.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:
(a) Future options to avoid the use of restraint;
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
(d) Whether the desired outcome was achieved;
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education for service providers.

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

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 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. Restraint monthly meetings are held. The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

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

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

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

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk

management system. The infection control committee includes a cross section of staff all areas of the service. The committee and the governing body are responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. There are monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the staff meetings. Minutes are available for staff. Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. There is a staff health policy. There have been no outbreaks.

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator - at the time of audit the clinical manager was handing responsibility over to one of the RNs - and both have completed appropriate IC training (including Bug Control – CM, the RN IPC). The orientation package includes specific training around hand washing and standard precautions and the CM and RN (i.e. IC coordinator) confirm the IC coordinator provides training both at orientation and ongoing. Training on infection control was last provided January 2014 (five attended). Toolbox talks have been provided around (but not limited to); minimising UTIs, and hand hygiene. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

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.)*