

# Bupa Care Services NZ Limited - Waireka Care Home

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Current Status: 13 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

Waireka 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) and rest home level care for up to 59 residents. The facility manager and clinical nurse manager are well qualified for their roles. The manager has many years' clinical experience including 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 Waireka. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There have been two lounges used as resident rooms that are suitable for one rest home and/or hospital level resident at any one time once the identified improvement to the environment is addressed. This will increase the capacity to 62 residents.

In addition there are four improvements required around short term care planning, documentation, restraint documentation and fridge temperature monitoring.

## Audit Summary as at 13 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 13 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.
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### Organisational Management as at 13 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.
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### Continuum of Service Delivery as at 13 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.
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### Safe and Appropriate Environment as at 13 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.
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### Restraint Minimisation and Safe Practice as at 13 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.
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## Infection Prevention and Control as at 13 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.
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## Audit Results as at 13 May 2014

### Consumer Rights

Waireka 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

Waireka 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. Waireka is benchmarked in two of these (hospital and rest home). 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 one improvement required around documentation.

### Continuum of Service Delivery

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the long term support plan to guide staff in the safe

delivery of care to residents. The care plans are goal oriented and reviewed every three months with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. An improvement is required around the documentation wound care interventions, restraint risks and behaviour monitoring. The diversional therapist and one activity assistant co-ordinate the combined rest home and hospital activity programme that meets the individual needs, preferences and abilities of the residents. Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency test and receive annual education. All baking and meals are prepared and cooked on-site. Residents' food preferences are identified at admission. This includes consideration of any particular dietary preferences or needs (including cultural needs).

### **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 spacious and all have hand basins. Some hospital rooms have ensembles. There are improvements required around the conversion of one of two lounges to resident bedrooms. 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 spacious lounges in the rest home and hospital areas. There are adequate toilets and showers for communal use. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Linen is laundered off-site. Cleaning and personal 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 hold a current first aid certificate. The facility has radiator heating in the communal areas and bedrooms.

### **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. There is a service restraint co-ordinator and restraint group with defined responsibilities including for the approval of restraints. The service has three residents assessed as requiring restraint and there are no enablers in use. A register is completed for each restraint. Restraint assessments are based on information in the care plan, discussions with residents and/or families and on staff observations of residents. Restraint is reviewed for each individual through the restraint group meetings and as part of the three monthly multidisciplinary review. Reviews include the resident (as appropriate) and family/whanau. Restraint usage throughout the organisation is monitored and benchmarked. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly. There is an improvement required around the documentation of restraint risks in the care plans.

## **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 (registered nurse) 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)

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## 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

<b>Legal entity name:</b>	Bupa Care Services NZ Limited		
<b>Certificate name:</b>	Bupa Care Services NZ Limited - Waireka Care Home		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Certification Audit		
<b>Premises audited:</b>	Waireka Care Home		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 13 May 2014	<b>End date:</b> 14 May 2014	
<b>Proposed changes to current services (if any):</b>	Two rooms previously used as lounges, being assessed for use by rest home and/or hospital level residents. At the time of audit a bathroom in the rest home area is being converted to a bedroom. This room will be suitable for rest home level only. These changes will take the total bed numbers to 62.		
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			54

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	14	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	14	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	28	Total audit hours off site	18	Total audit hours	46
Number of residents interviewed	9	Number of staff interviewed	17	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	58	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Wednesday, 4 June 2014

## Executive Summary of Audit

### General Overview

Waireka 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) and rest home level care for up to 59 residents and increase to 62 following the outcome of this audit. On the day of the audit there were 23 hospital residents, 31 rest home residents. Waireka facility manager and clinical nurse manager are well qualified for their roles. The manager has many years' clinical experience including 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 Waireka. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. There have been two lounges used as resident rooms that are suitable for one rest home and/or hospital level resident at any one time once the identified improvement to the environment is addressed. In addition there are four improvements required around short term care planning, documentation, restraint documentation and fridge temperature monitoring.

### Outcome 1.1: Consumer Rights

Waireka 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

Waireka 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. Waireka is benchmarked in two of these (hospital and rest home). 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 one improvement required around documentation.

### **Outcome 1.3: Continuum of Service Delivery**

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the long term support plan to guide staff in the safe delivery of care to residents. The care plans are goal oriented and reviewed every three months with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. An improvement is required around the documentation wound care interventions, restraint risks and behaviour monitoring. The diversional therapist and one activity assistant co-ordinate the combined rest home and hospital activity programme that meets the individual needs, preferences and abilities of the residents. Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency test and receive annual education. All baking and meals are prepared and cooked on-site. Residents' food preferences are identified at admission. This includes consideration of any particular dietary preferences or needs (including cultural needs).

### **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 spacious and all have hand basins. Some hospital rooms have ensuites. There are improvements required around the conversion of one of two lounges to resident bedrooms. 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 spacious lounges in the rest home and hospital areas. There are adequate toilets and showers for communal use. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Linen is laundered off-site. Cleaning and personal 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 hold a current first aid certificate. The facility has radiator heating in the communal areas and bedrooms.

### **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. There is a service restraint co-ordinator and restraint group with defined responsibilities including for the approval of restraints. The service has three residents assessed as requiring restraint and there are no enablers in use. A register is completed for each restraint. Restraint assessments are based on information in the care plan, discussions with residents and/or families and on staff observations of residents. Restraint is reviewed for each individual through the restraint group meetings and as part of the three monthly multidisciplinary review. Reviews include the resident (as appropriate) and family/whanau. Restraint usage throughout the organisation is monitored and benchmarked. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly. There is an improvement required around the documentation of restraint risks in the care plans (link 1.3.6.1).

### **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 (registered nurse) 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
<b>Standards</b>	0	46	0	4	0	0	0
<b>Criteria</b>	0	97	0	4	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	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 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	Eight resident files were reviewed and the time of entries is inconsistently recorded with a tendency to use 'am', 'pm'.	Record the time of entry when writing progress notes in resident files.	90
HDS(C)S.2008	Standard 1.3.6: Service	Consumers receive adequate and appropriate services in	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Delivery/Interventions	order to meet their assessed needs and desired outcomes.				
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There is no documented pressure area management and interventions for resident with grade one sacral pressure area. ii) There is no behaviour monitoring or de-escalation techniques documented for resident with memory loss, repetitive behaviours and depression. iii) a) There is no short term care plan for one wound. b) There is no evaluation for a short term wound care plan in place. c) There is no documented evaluation for one chronic wound described as "deteriorating" in April 2014. d) The dressing change for one wound had not been documented as completed, at the required frequency.	Complete documentation appropriate to clinical need.	60
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and	PA Low	There is inconsistent monitoring of facility resident fridges. There is no evidence of corrective	Resident fridge temperatures are monitored and corrective actions undertaken when outside of	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		disposal comply with current legislation, and guidelines.		actions for temperatures outside of the acceptable range.	the acceptable range.	
HDS(C)S.2008	Standard 1.4.4: Personal Space/Bed Areas	Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	PA Low			
HDS(C)S.2008	Criterion 1.4.4.1	Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.	PA Low	(i)There is a screen used for one room instead of a door, which does not always ensure privacy. (ii) The second lounge converted to a bedroom includes the external fire exit door.	(i)Ensure resident privacy is maintained. ii) Obtain fire service approval regarding use of lounge for bedroom.	60

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> 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 (four work across rest home and hospital and one who works primarily with one young person) demonstrate an understanding of the Code. Resident rights/advocacy training was provided March 2014 (nine attended). Residents interviewed (seven rest home and two hospital) and relatives (four hospital) 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.

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

## 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 of Rights (CoR) 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 meetings also provide the opportunity for residents to raise issues/concerns (minutes sighted). Residents interviewed (seven rest home and two hospital) and relatives (four hospital) inform information has been provided around the Code. The facility 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, CoR pamphlet, advocacy and Health & Disability Commission. The Facility 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The confidentiality and resident privacy policy states the facility 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 (7 staff attended). A resident satisfaction survey was completed in July 2013 (just after Bupa purchasing Waireka) that resulted in a 77% overall satisfaction with the service – including 79% of respondents were satisfied that staff took the time to know residents.</p> <p>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 residents (seven rest home and two hospital) and relatives (four hospital) inform staff are respectful. There is an abuse and neglect policy that is being implemented and staff attend in-service education on abuse and neglect (March – 7 attended). Interviews with residents and family members were extremely positive about the care provided.</p> <p>D4.1a Eight 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 residents confirm their values and beliefs were considered.</p> <p>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</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are</p>

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A3.2 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.

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:**

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

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> 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 four relatives inform values and beliefs are considered. Discussion with residents (seven rest home and 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>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. There is policy to guide staff practice: Gift, Gratitude's and Benefits, Delegations of Authority. Clinical meetings occur with the RNs monthly 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 nurse manager, two registered nurses confirm an awareness of professional boundaries. Waireka is providing intermittent care for a young person and five caregivers could also discuss boundary issues in relation to care.</p>

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>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.</p> <p>Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services and Waireka is benchmarked in the hospital and rest home. 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 a corrective action plan were sighted relating to skin tears where a recurring trend was emerging above the benchmark. Actions were in place (plan developed 10 May). 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 Waireka supported by a number of meetings held on a regular basis.</p> <p>ARC A2.2 Services are provided at Waireka that adhere to the health &amp; disability services standards. There is an established quality improvement programmes that includes performance monitoring. 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.</p> <p>There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants. Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). This is in the process of being implemented at Waireka. There are 10 caregivers who have attained bronze (33%), 9 who have attained silver (30%) and 8 (26.6%) who have attained gold.</p>

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 and registered nurses. Standardised annual education programme, core competency assessments and orientation programmes are being implemented at Waireka. Competencies are completed for key nursing skills at Waireka 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 (seven rest home and two hospital) and relatives (four hospital) were positive about the care they receive. Waireka 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 facility manager is a RN with extensive clinical experience and was observed to be a strong mentor for the clinical team.

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> 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. 11 incident forms reviewed from across 2014 (both 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 Waireka. 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 relatives (four hospital) 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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code. Required consent forms and advance directive forms are evident on eight of eight resident files reviewed including the respite care file. Discussions with five caregivers (rest home and hospital) confirmed that they were familiar with the requirements to obtain informed consent for personal cares and entering rooms. Discussions with three registered nurses identified that staff are 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. Completed resuscitation treatment plan forms were evident on all eight resident files reviewed including the respite care resident file.</p> <p>D13.1 There are seven admission agreements sighted for long term residents and all seven agreements have been signed. There is short stay agreement which has been signed by the respite care resident.</p> <p>D3.1.d Discussion with four family (hospital) identified that the service actively involves them in decisions that affect their relative's lives.</p>

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry (sighted). Interviews with the facility manager, the administrator and the clinical nurse manager confirm practice. Interviews with residents (seven rest home and two hospital) confirm that they are aware of their right to access advocacy. D4.1d; Discussions with four 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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D3.1h: Interview with nine residents and four 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. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with nine 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 diversional therapist, four relatives and nine residents confirm that residents are supported and encouraged to remain involved in the community and external groups.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The complaints procedure (065) states 'the facility 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 nine residents and four relatives confirm they were provided with information on complaints. Complaint forms were visible for residents/relatives in various places around the facility. There is only one complaint between January and May 2014 and there is well documented investigation, follow up and resolution. There are a significant number of compliments for this same period, with response letters attached.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry</p>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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 Waireka provides care for up to 59 residents across two service levels (rest home and hospital). On the day of audit there were 31 of 37 rest home residents and 23 of 22 hospital residents. There are no residents under the medical component at the time of audit. The 59 includes three GP beds – one occupied at the time of audit. This audit considered two rooms previously used as lounge areas and both can accommodate one resident of either hospital or rest home level (link1.4.4), and one bathroom that is being converted into a bedroom. This room can be used for rest home level resident only. Including these three extra rooms, the facility has the capacity to care for a total of 62 residents.

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. Waireka 2014 quality goals include: complying with weight management procedures and reduce accident and incidents relating to bruising and skin tears. Progress is reported through the quality meetings. Waireka 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'.

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. Waireka is part of the central Bupa region which includes eight facilities. The managers in the region teleconference monthly and meet six monthly. A forum is held every six months (with national conference) including all the Bupa managers. Waireka is implementing the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa Way (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 Waireka. 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 facility manager at Waireka for coming up one year, prior to this time she was the clinical manager and joined the team as a RN in 2012. She has extensive clinical experience including DHB, community and in the Pahiatua Hospital when the service operated. The clinical nurse manager since July 2013. 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 nurse 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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 nurse 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Waireka 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 implemented 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 &amp; 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. The release is notified by email to all clinical/facility 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.</p> <p>Key components of the quality management system link to the quality meetings at Waireka who meet monthly. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly</p>

accident/incident benchmarking reports completed by the clinical nurse manager that break down the data collected across the rest home, dementia unit and hospital services, and staff incidents/accidents. The service has linked the complaints/compliments 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/compliments. The Waireka infection control committee meet monthly and the weekly reports from the facility 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.

Waireka 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. Corrective actions resulting from the internal audit programme were seen to have been closed out. 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 Waireka via graphs and benchmarking reports. 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. A corrective action plan is completed when an indicator exceeds the KPI rate by 3.0. While Waireka has not exceeded the KPI rate by 3.0 against any indicator an emerging trend (across a 3 month period) can be seen relating to skin tears and bruising. A corrective action plan has been developed (10 May 2014).

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 Waireka and document actions that have improved outcomes or efficiencies in the facility.

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 (H&S) 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 Waireka 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:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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:** FA

**Evidence:**

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting category one incidents. The completed form is forwarded to the quality and risk team as soon as possible (definitely within 24 hours of the event), even if an investigation is on-going. 11 incident forms were reviewed between January 2014 (to date). All forms were completed appropriately, including clinical manager review and facility manager sign out. Families were reported as having been notified in all reviewed.

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. A corrective action plan is required when an indicator exceeds the KPI rate by 3.0. While Waireka has not exceeded the KPI rate by 3.0 against any indicator an emerging trend (across a 3 month period) can be seen relating to skin tears and bruising. A corrective action plan has been developed (10 May 2014).

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:** 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 1.2.7: 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 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. Seven staff files were reviewed (clinical nurse manager, two registered nurses, two caregivers, cook, diversional therapist) 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 – two buddies were interviewed. Staff interviewed (five caregivers, three registered 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 nurse manager confirm the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards (sighted in files reviewed). 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 - e.g. 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 confirm 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 are 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.

#### **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.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

There is an RN and first aid trained member of staff on every shift. Interview with five caregivers inform the RN's are supportive and approachable. There is a qualified diversional therapist at the facility.

Interviews with staff, residents and relatives inform there are sufficient staff to meet the care needs of the residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (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:** PA Low

**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. Entries in resident files do not consistently record the time of entry and this is an area of improvement. 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:**

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

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> In the resident files reviewed there is inconsistent recording of the time of the entry and this is an area of improvement.
<b>Finding:</b> Eight resident files were reviewed and the time of entries is inconsistently recorded with a tendency to use 'am', 'pm'.
<b>Corrective Action:</b> Record the time of entry when writing progress notes in resident files.
<b>Timeframe (days):</b> 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

All records pertaining to individual consumer service delivery are integrated.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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. Nine residents (five rest home, two hospital, and two in GP beds) and four relatives (hospital) interviewed stated they were well informed upon admission. The service has a well-developed enquiry information pack available for potential residents and an admission pack /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 H&D Code of Rights, how to access advocacy and the health practitioners code. There is a resident handbook included in the information pack. The clinical manager screens all admissions to ensure a needs assessment has been completed and the service can provide the level of care. A medical handover is required to the receiving GP. There is an admission policy; a resident admission procedure and a documented procedure for respite/short stay resident admissions.

### 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 is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Potential residents would be referred back to the referring agency if entry was declined. The service has not declined any potential residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c.i; 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:**

The service provides for hospital and rest home level of care. The service has GP beds and provides respite care at rest home and hospital level. D.16.2, 3, 4: The eight resident files sampled (three hospital, one hospital respite and four rest home) identified that the registered nurses (RN) complete an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whānau participation and involvement provide the basis for the initial assessment and initial support care plan.

Seven files sampled identified that the long term support plan is developed within three weeks. The development of one long term care plan was delayed due to the resident being admitted to hospital. All eight long term care plans sampled are signed and dated by the RN. Families confirmed on interview they are invited to attend the multidisciplinary care plan reviews and GP visits. The diversional therapist (DT) completes an activity assessment, "Map of Life" and individual activity care plan in consultation with the resident/family/whanau as appropriate.

D16.5e: Seven of seven long term resident files sampled identified that the GP had seen the resident within two working days. The respite care resident had been seen by their GP since admission. A current medical history is in the resident record. It was noted in all long term resident files sampled that the GP has examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. All resident files sampled identified integration of allied health professionals and a team approach. There are two local general practitioners who provide medical care to the residents. There is a weekly visit to the facility for routine reviews and any RN resident concerns.

The GP (interviewed) states the GP's provide a 24/7 cover for the service. The GP's are available to meet with families. The GP is complimentary of the care provided to the residents and RN clinical assessments. GPs are involved in three monthly multidisciplinary (MDT) reviews. GP communication charts ensure all nursing concerns and documentation requirements are addressed at the weekly visit or earlier as required. There is close liaison with the geriatrician, hospice and oncology services and mental health services for the older person. Services are readily available. The staff have received positive feedback regarding palliative care services. Family donations have gone towards the "Rimu" palliative care room that provides a comfortable environment for the resident and their family/whanau.

There is a verbal handover and written handover (report book) at the beginning of each shift for all staff (rest home and hospital). Staff are required to read short term care plans in place, progress notes and care summaries. A communication diary is in place. The rest home duty leader (interviewed) states the communication system is good and they receive relevant information at handover to deliver safe and timely cares for the residents.

A podiatrist visits three monthly and a RN from the health centre provides nail care on a weekly basis. Other services such a physiotherapy is by referral.

Tracer methodology: Rest home resident

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

Tracer methodology: Hospital level of care

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:**

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

**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.

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Waireka rest home and hospital use the Bupa assessment booklets and lifestyle templates for all residents. The assessment booklet provides in-depth assessment tools including; falls, Braden pressure area, skin, mini nutritional, continence, pain, dependency and activities. Additional risk assessment tools include behaviour, cultural and wound assessments as applicable. The outcomes of risk assessments are reflected in the care plan. 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.

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health. The long-term care plan is

completed within three weeks in six of eight residents files sampled. One resident is on respite care and another resident had a hospital admission delaying the development of the care plan. There is a long term lifestyle care plan that includes; a) hygiene, b) medical, c) skin and pressure area care, d) bladder and bowels, e) mobility, f) food and fluids, g) rest and sleep, h) communication, i) emotional well-being, j) spirituality, k) religion and culture, and l) activities. Lifestyle care plans demonstrate service integration. Long term residents' care plans reviewed on the day of the audit (four rest home and three hospital) provide evidence of individualised support, however there is an improvement required around the documentations of interventions (link 1.3.6.1). Residents and families interviewed confirm care delivery and support by staff is consistent with their expectations.

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

D16.3f The eight resident files reviewed identified that the resident/family/whanau have the opportunity to be involved in the care planning process.

**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.

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

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

Service delivery plans demonstrate service integration.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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:** PA Low

#### **Evidence:**

Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. Families confirm on interview they are notified of any changes to their relative's health including accident/incidents, infections, GP visits, appointments etc. Discussions with families are documented on the family contact form in the resident file. Five caregivers (rest home and hospital) and three RNs interviewed state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); electric beds, ultra-low beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists (checked 10/13), wheel on and stand on weigh scales (calibrated 10/13), transferring equipment, walking frames, wheelchairs, gloves, masks and aprons.

Adequate dressing supplies are available. Wound management policies and procedures are in place. Wound assessment and wound management plans are in place for six skin tears (five rest home, one hospital), leg ulcer (rest home) and two sacral pressure areas (one rest home and one hospital). Chronic wounds are linked to the care plan. The GP is notified of any non-healing wounds as evidenced in the GP notes. There is evidence of a surgical referral and wound nurse involvement in wound management. Turning charts are in place for pressure area management. There is an improvement required around wound management documentation. Continence products are available and resident files include and management a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. The clinical manager (interviewed) described the referral process and related form should they require assistance from a wound specialist, continence nurse, dietitian, speech language therapist, diabetes nurse or other allied health or nursing specialists.

There are a number of monitoring forms in place that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, food and drinks list, blood sugar monitoring, bowel records, continence diary, restraint monitoring and neurological observations. There is an improvement required around the documentation of interventions in care plans to reflect the residents current needs. Risks associated with the use of restraint and management and interventions for behaviours associated with memory loss and depression.

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

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

**Attainment and Risk:** PA Low

#### **Evidence:**

Wound assessment and wound management plans are in place for six skin tears (five rest home, one hospital), leg ulcer (rest home) and two sacral pressure areas (one rest home and one hospital). Chronic wounds are linked to the care plan. The GP is notified of any non-healing wounds as evidenced in the GP notes. There is documented evidence of a surgical referral and wound nurse involvement in wound management. Turning charts in place for pressure area management.

**Finding:**

There is no documented pressure area management and interventions for resident with grade one sacral pressure area. ii) There is no behaviour monitoring or de-escalation techniques documented for resident with memory loss, repetitive behaviours and depression. iii) a) There is no short term care plan for one wound. b) There is no evaluation for a short term wound care plan in place. c) There is no documented evaluation for one chronic wound described as “deteriorating” in April 2014. d) The dressing change for one wound had not been documented as completed, at the required frequency.

**Corrective Action:**

Complete documentation appropriate to clinical need.

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

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

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

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

**Attainment and Risk:** FA**Evidence:**

The service employs a qualified diversional therapist (DT) for 35.5 hours per week Monday to Friday with flexibility to work on Saturdays for special events. The DT attends on-site education, has a current first aid certificate and attended DT conference September 2013. The DT is supported by an activity officer two hours per day Monday to Friday. Bupa DT team meetings are held two monthly. The programme is planned three weeks in advance with the current week displayed throughout the facility. There is a team of volunteers who assist with the programme such as reading current affairs, shopping and gentle exercises. Tai Chi is taken by an instructor from the local primary health organisation. The programme is developed to ensure residents have a choice of two activities to attend. Activities include (but not limited to); board games, short stories, happy hour, music and entertainment (weekly), movies, crafts, baking, jigsaws, chair bowls and quizzes. One on one activities take place for residents who do not wish or are unable to participate in group activities. Interhome rest homes visits occur between three regional homes. There are outings to community groups such as 500 card group, Age Concern rest home games, RSA meetings and women’s group, probus, shopping and attending the country and western club. The service has a wheelchair access van and all drivers complete a van hoist competency. Festive occasions and theme days are celebrated such as a trip to lavender farm for mother’s day, Melbourne cup day, BUPA mad hatters tea party and a trip to Wellington on the train is planned as well as involvement in BUPA wearable arts event. Interdenominational church services are held fortnightly with Catholic services weekly. There are three lounges, a recreation room, craft room and “man cave” where group and individual activities can take place. Ten residents interviewed are very happy with the choice and variety activities offered. Resident meetings provide an opportunity for feedback and suggestions on the programme, outings and entertainment. All residents have an activity assessment, “Map of Life” and activity plan developed in consultation with the resident/family/whanau as appropriate. There is a co-ordinated approach to the review of the activity care plan with the DT involved in the multidisciplinary review. Monthly progress notes and activity participation register is maintained.

**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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  D16.4a: Care plans are evaluated by the registered nurses six monthly(rest home) and three monthly (hospital) or when changes to care occur as sighted in five of seven long term resident files sampled. One rest home resident and one hospital resident have not been at the service six months. Short term care plans for short term needs are evaluated and either resolved or added to the long term care plan as an on-going problem with (exceptions link 1.3.6.1). The multidisciplinary review involves the clinical manager, RN, DT, GP and family/resident. The family are notified of the outcome of the review by phone call and if unable to attend they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. Families confirmed on interview they are invited to attend the multidisciplinary care plan reviews and GP visits.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Referral to other health and disability services is evident in 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 needs assessor, elder health, physiotherapy, dietitian, mental health services, diabetes nurse specialist, and hospital specialists. D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care from respite to rest home level. D 20.1 discussions with three registered nurses identified that the service has access to GPs, ambulance/ emergency services, allied health, dietitians, physiotherapy, continence and wound specialists and social workers.

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made.</p>

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

**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:** FA

**Evidence:**

The hospital wing has the main medication with pharmaceutical supplies, controlled drugs safe, clinical equipment and dressing supplies. There is a locked medication room in the rest home area. The supplying pharmacy delivers the regular monthly robotic rolls and "PRN" medication (also in robotic rolls). A registered nurse (RN) and one other medication competent person check the medications on delivery. Any discrepancies are fed back to the supplying pharmacy. Returns are stored safely in the keypad medication room until collected. There are two drug safes, one for liquid controlled drugs and the other for the hospital bulk order supply. RN's have attended palliative care training (April 2014) and have syringe driver competencies. Prescribed controlled drugs for residents are dispensed in blister packs and locked safely in the medication cupboard. There is evidence of a pharmacy six monthly audit (April 2014). Oxygen and suction is available (checked November 2013) and checked weekly. Emergency medications include adrenaline and glucagon. There is a supply of antibiotics for GP prescribing outside of pharmacy hours. All stock and expiry dates are checked weekly. There are no standing orders. GP verbal orders are taken as necessary and have been signed off within the required timeframe. RNs and caregivers who complete annual medication competency and education administer medications. There is a current signature list for medication competent persons. Medication management audit in February 2014 identified issues around self-administration. On the day of audit self-administration consent forms are in place and reviewed by the resident, RN and GP three monthly. Medications are stored safely in the resident's room and there is monitoring of self-administration. Medication trolley (rest home and hospital) contents are checked and all eye drops are dated on opening. Medication fridge temperatures are monitored daily and there is evidence of corrective action for temperatures outside of the acceptable range. There are no signing gaps in 16 of 16 signing sheets sampled. Controlled drugs and insulin is double signed. There are guidelines for the management of hypoglycaemia and hyperglycaemia in the medication folder. Blood sugar levels are monitored and recorded. There are a number of diabetic residents with eight being in the rest home. The staff are knowledgeable in the management of diabetes. There is documented evidence of a recent hypoglycaemic episode being treated according to protocol. Sixteen of 16 medication charts sampled (eight rest home and eight hospital) all have photo identification and allergy status noted. Five of 16 medication charts did not have an indication for "PRN" use. The GP corrected this during the audit. 16 of 16 medication charts have been reviewed three monthly by the GP.

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

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

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

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

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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.

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

**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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>The cook (qualified chef) on duty (interviewed) is knowledgeable in the food services policies and procedures for Bupa. The cook is on duty from 9am-5.30pm daily and is supported by one kitchen hand in the morning and an evening kitchen hand. The national six weekly menus have been audited and approved by the dietitian. Variations to the menu are recorded. All meals and baking is done on site. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. This is reviewed as part of the care plan review. There is specialised crockery such as lip plates and mugs to promote resident independence with meals. Alternative choices are offered for dislikes and this is confirmed on resident interviews. Special diets are catered for including organic and raw fruit diet, soft and pureed meals. There is a kitchen whiteboard that details resident likes and dietary requirements. Currently there are no residents with weight loss. Meals are served from bain maries in the rest home and hospital dining rooms. End cooked and serving temperatures on hot foods are monitored and recorded daily. There is a well equipped kitchen with a good work flow, entry and exit door, external delivery area, refrigerators, freezers and walk-in chiller. Inwards goods are temperature checked on</p>

arrival. All foods in the fridge, chiller and freezer are date labelled. There is daily temperature monitoring of fridges and freezers within the kitchen. There is an improvement required around the monitoring of facility resident fridges and corrective actions for temperatures outside of the acceptable range. A cleaning duties list is maintained (sighted). The maintenance person undertakes cleaning duties such as walls and ceilings. The kitchen is locked when unattended. Residents have the opportunity to provide feedback on the menu and food services through the resident meeting. Meeting minutes are available to the food services team. Food services staff are due to attend food safety and hygiene refresher in June 2014. Staff have attended chemical safety training.

**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.

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> There is a well equipped kitchen with a good work flow, entry and exit door, external delivery area, refrigerators, freezers and walk-in chiller. Inwards goods are temperature checked on arrival. All foods in the fridge, chiller and freezer are date labelled. There is daily temperature monitoring of fridges and freezers within the kitchen.
<b>Finding:</b> There is inconsistent monitoring of facility resident fridges. There is no evidence of corrective actions for temperatures outside of the acceptable range.
<b>Corrective Action:</b> Resident fridge temperatures are monitored and corrective actions undertaken when outside of the acceptable range.
<b>Timeframe (days):</b> 90 (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is a chemical/substance safety policy. 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 and education was conducted in February 2014 around chemical safety. All chemicals are clearly labelled with manufacturers labels. Safety data sheets are available. A spills kit is in place. 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

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building holds a current warrant of fitness which expires on 11 August 2014. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged next due November 2015. Reactive and preventative maintenance occurs. There is a 52 week planned maintenance programme in place. All medical equipment was calibrated October 2013. There is a maintenance person on staff. All hoists and electric beds have been serviced and checked October 2013. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents are observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating with shade sails in place. There is wheelchair access to all areas. There is a designated resident smoking area.

ARC D15.3, The following equipment is available, electric beds, ultra-low beds, pressure relieving mattresses, shower chairs, hoists, mobility aids, sensor mats and wheel-on scales.

### 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.

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

**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.

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms have hand basins. There are some hospital level bedrooms with ensuites. There are adequate communal toilets and shower rooms in each rest home and hospital wing. There is appropriate signage with easy clean flooring and fixtures. Privacy curtains are in place. Privacy locks indicate whether the communal toilet/showers are vacant or in use. There is a spa bath available. Nine residents interviewed (two hospital, five rest home - including one respite and two GP beds) report their privacy is maintained at all times.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The hospital bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Five caregivers (rest home and hospital) and

three RNs (interviewed) report that rooms have sufficient rooms to allow cares to take place. There are wide doors in the hospital area for bed evacuation or ambulance trolley access. Residents are encouraged to personalise their bedrooms as sighted. Two lounges in Zone 1 have been converted to bedrooms. These are of appropriate size for hospital level care residents. One lounge has a standing screen across the doorway. A door is required for privacy purposes. The second lounge converted to a bedroom includes the external fire exit door. The fire service will need to be contacted to consider the impact on the evacuation plan. A bathroom is currently being converted to a bedroom for rest home use only.

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Two lounges in Zone 1 have been converted to bedrooms. These are of appropriate size for hospital level care residents. One lounge has a standing screen across the doorway. A bathroom is currently being converted to a bedroom for rest home use only.
<b>Finding:</b> (i)There is a screen used for one room instead of a door, which does not always ensure privacy. (ii) The second lounge converted to a bedroom includes the external fire exit door.
<b>Corrective Action:</b> (i)Ensure resident privacy is maintained. ii) Obtain fire service approval regarding use of lounge for bedroom.
<b>Timeframe (days):</b> 60 (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are spacious lounges and dining rooms in the rest home and hospital area. Smaller lounges are available for small group or individual activities or for visitors. Tea and coffee making facilities are available. There is a large activity room with a kitchenette. A smaller lounge is the “man cave” also with tea and coffee making facilities. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this. The hospital dining room and lounges accommodate specialised lounge chairs. D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are policies including - cleaning department - use of equipment policy and a cleaning schedules in place. There is also a cleaning schedule/methods policy for cleaners . All linen is sent off site Monday to Friday and picked up through an external entrance. Clean linen is delivered sealed in plastic wrapping. There is adequate linen supplies sighted in the faciilty linen store cupboards. All resident personal clothing and kitchen washing is done on site. There is a dedicated lauundry person Monday to Friday for six hours a day. Chemicals are stored safely in the laundry area. Safety data sheets are readily available. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles. An auto dispenser is used for the re-filling of chemical bottles. Laundry staff have attended training in chemical safety and launder care. There is a dedicated cleaner for seven hours per day Monday to Sunday. Cleaning trolleys are well equipped and cleaning products are stored safely. Cleaning schedules are maintained. Commercial cleaners are contracted for window cleaning. The service has two vax machines for the cleaning of carpets. The “resident of the day” receives a special “spring clean“ of their room. The cleaner (interviewed) is the health and safety (H&amp;S) rep and attends the H&amp;S meetings. Cleaners have attended chemical safety. There is sluice room for the disposal of soiled water or waste. Personal protective equipent is available in the laundry, cleaning and sluice room. Staff are observed to be wearing appropriate protective wear. Nine residents interviewed (two hospital, five rest home – including one respite and two GP beds) are happy with the laundry and cleaning services provided</p>

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety was last held in March 2014 (11 attended). Fire evacuations are held six monthly and the last drill was 14 April and repeated 1 May 2014. 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 21/08/99). 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 personal protective equipment (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. A test of a resident call bell (hospital) showed a response of less than one minute.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

The lounge areas were noted to have 'emergency' call bells only. Interview with staff inform if they require routine assistance when in these lounge areas, they have to leave the lounge to find a colleague. Residents were not seen to be left unattended in these areas during the audit. This is noted to have been followed up by the Operations Manager during the audit.

### 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.

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The facility has radiator heating throughout communal areas and corridors. Each bedroom has radiator heating that is individually thermostat, controlled. All communal rooms and bedrooms are well ventilated and light. Nine residents interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident's rooms.

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

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

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

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

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

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

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

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## 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 Bupa regional restraint co-ordinator at an organisation level that reviews restraint practices and provides education and support to service restraint co-ordinators. The regional restraint co-ordinator is readily available by teleconference. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has three restraints (lap belts) in use. There are no enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is.

#### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Only staff that have completed a competency assessment are permitted to apply restraints. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. Interview with the restraint coordinator and review of signed job description (July 2013) identified understanding of the role. Annual education is attended by all clinical staff. Newly appointed staff receive one on one education during the orientation period. The organisational restraint group approve the type and use of restraints. Meeting minutes are available for staff. Restraint usage is a set staff agenda item. There is provision for emergency restraint as assessed by the registered nurse on duty in consultation with the restraint co-ordinator.

#### Evidence:

### 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.

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

#### 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 suitably qualified and skilled staff in partnership with the resident and their family/whanau. A registered nurse is the restraint coordinator. 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 and this has been completed for the three residents requiring lap belts 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. Three restraint files were reviewed in the hospital (lap belts). All included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these are reviewed monthly.

### 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. There are approved restraints documented in the policy. The restraint coordinator is a registered nurse and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed at least six monthly within the facility restraint meeting and also as part of three monthly restraint register reviews. The use of restraint is included in the care plans however there is an improvement required around the documentation of risks associated with the use of restraint (link 1.3.6.1).

Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. Advised by the restraint coordinator 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 residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of two hospital residents with restraint identified observations and monitoring. Restraint use is reviewed through the three monthly assessment evaluation, three monthly restraint meetings and six monthly multidisciplinary meeting and includes family/whanau input. A restraint register is in place. 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:**

Restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred three monthly as part of the on-going reassessment for the residents on the restraint register, and as part of care plan review. The GP is involved in the three monthly review. Families are included as part of this review or notified of the outcome of the review if unable to attend. A review of three files identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed on a formal basis through restraint group meetings. Evaluation timeframes are determined by risk level.

**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:**

The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings and regional restraint meetings. Restraint use is reviewed through the three monthly assessment evaluation, two monthly restraint meetings and three monthly multidisciplinary meeting and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint. The restraint co-ordinator provides a monthly report on restraint usage to the national restraint co-ordinator. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at Regional Restraint Approval group.

**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.

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

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

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### 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 was a norovirus outbreak in August 2013 that is well documented and managed.

#### 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.

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the infection control coordinator (RN), facility manager, clinical nurse manager, and other staff. The facility also has access to an infection control nurse special list, 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.

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

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

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

ARC D5.4e ARHSS D5.4e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed appropriate IC training (Bug Control in March 2014). The orientation package includes specific training around hand washing and standard precautions. The IC coordinator provides training both at orientation and on-going. Training on infection control is included in as part of the annual training schedule. In addition toolbox talks are 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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 coordinator. 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 facility 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.

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