# Bupa Care Services NZ Limited - Te Puke Country Lodge

## Current Status: 17 July 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

Te Puke Country Lodge is part of the Bupa group. The service provides hospital and rest home level care for up to 81 residents. On the day of audit there were 71 residents, 35 at rest home level care and 36 at hospital level care.

Te Puke was purchased by Bupa Care Homes on 16 September 2013. The transition has been completed from a family owned and operated care home to a corporate one. All Bupa systems are now in place. Te Puke is managed by an experienced registered nurse who was on leave on the day of audit. An interim manager was appointed until the manager returns to work. The interim manager is an experienced manager who has been with Bupa for many years. She is supported by a clinical manager who is a registered nurse and new to Bupa services. He has previously worked in an aged care management role. He has been at the service for four months. The Bupa regional manager (RN) also supports the facility manager.

This audit identified improvements required around documentation of interventions, infection control surveillance, scheduled meetings, documentation of the orientation programme and maintenance of a complaints register.

## Audit Summary as at 17 July 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 17 July 2014

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

### Organisational Management as at 17 July 2014

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

### Continuum of Service Delivery as at 17 July 2014

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

### Safe and Appropriate Environment as at 17 July 2014

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

### Restraint Minimisation and Safe Practice as at 17 July 2014

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

### Infection Prevention and Control as at 17 July 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. |  | Some standards applicable to this service partially attained and of low risk. |

## Audit Results as at 17 July 2014

### Consumer Rights

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is clearly visible throughout the facility. Staff and management interviews demonstrate an awareness of consumers' rights and their obligation. Residents/relatives are informed concerning the code of rights. Staff are educated through the training schedule ensuring knowledge of consumer rights. Information on access to advocacy services is provided to residents and relatives on admission. Te Puke has an appointed advocate who visits residents. There are three residents that identify as Maori. Te Puke acknowledges the cultural safety issues for Maori and can manage these on an individual basis.

There are policies and procedures around culture and the delivery of culturally safe services. Residents and family members spoken with showed awareness of their own culture and said this was respected by staff and management in the provision of care. The assessment process is implemented with all residents that incorporate individual’s beliefs, values and spiritual belief systems. This starts with the entry to service where information about culture, beliefs and preferences is recorded. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend this meeting. Family members assist residents to complete ' the map of life'. There is a complaints register that includes complaints, dates, and actions taken but not all complaints are recorded in the register. This requires improvement. Complaints are reported to head office and benchmarked against other facilities.

### Organisational Management

Te Puke has quality and risk management systems that support the provision of clinical care. Incidents and accidents are reported and immediate follow up is conducted by the registered nurses on duty and investigation is completed by the clinical manager or the facility manager. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Corrective actions are initiated according to benchmarking results. 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. There is a comprehensive health and safety and risk management programme in place.

There are human resources policies including recruitment, selection, orientation, and staff training and development. Bupa has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support, and external training is well supported. Caregivers have or are completing an ACE or Career force qualification in care of elderly. Improvements are required around implementation of scheduled meetings and documentation of individual orientation program.

### Continuum of Service Delivery

There is a comprehensive admission pack provided on entry to the service. All residents have a needs assessment prior to admission. 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 orientated and reviewed every six months with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. An improvement is required around the documentation of interventions in care plans to reflect the residents current needs.

The two activity co-ordinators implement the combined rest home and hospital activity programme that meets the individual needs, preferences and abilities of the residents. One-on- one time is spent with individual residents. Community links are maintained. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. 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 safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with ensuites and are personalised. 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 and a large recreation room. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has ceiling heating in the communal areas and electric panel heaters in the bedrooms.

### Restraint Minimisation and Safe Practice

Policies and protocols are congruent with NZS 8134.0. Restraint and enabler training is part of the orientation and included in the in-service education programme. Restraint minimisation and enabler training is provided throughout the year ensuring that all staff complete training. Restraint competencies are current. Staff interview also confirmed on-going training. In the hospital, there are eight restraints (four bedrails and four lap belts) and seven bedrails as an enabler. There is one lap belt as a restraint and no enablers in the rest home. Restraint minimisation procedures are implemented. These procedures include assessment of the least restrictive option, consent, monitoring and evaluation.

### Infection Prevention and Control

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an established and implemented infection control programme. The infection control committee includes a cross section of staff all areas of the service.

The committee and the governing body is responsible for the development of the infection control programme and its review. The facility has access to professional advice within the organisation and has developed close links with the GP's, the local laboratory service, the infection control and public health departments at the local DHB. Infection control matters are also discussed at the quality meetings and staff meetings. Regular audits take place and annual education and toolbox talks are provided for all staff. Benchmarking occurs against other Bupa facilities. Infection rates at Te Puke are below Bupa thresholds. An improvement required around documentation of infection control data.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## Introduction

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

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

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

## Audit Report

|  |  |
| --- | --- |
| **Legal entity name:** | Bupa Care Services NZ Limited |
| **Certificate name:** | Bupa Care Services NZ Limited - Te Puke Country Lodge |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Te Puke Country Lodge |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 17 July 2014 | **End date:** | 18 July 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 71 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX  | **Total hours on site** | 16 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 12 | Total audit hours | 44 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 9 | Number of staff interviewed | 11 | Number of managers interviewed | 6 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 6 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 91 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed |  |

## 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 Friday, 29 August 2014

## Executive Summary of Audit

**General Overview**

Te Puke Country Lodge is part of the Bupa group. The service provides hospital and rest home level care for up to 81 residents. On the day of audit, there were 71 residents, 35 at rest home level care and 36 at hospital level care. This includes one resident receiving respite care (hospital level).

Te Puke was purchased by Bupa Care Homes on 16 September 2013. The transition has been completed from family owned and operated care home to a corporate one. All Bupa systems are now in place. Te Puke is managed by an experienced registered nurse who was on leave on the day of audit. An interim manager was appointed until the manager returns to work. The interim manager is an experienced manager who has been with Bupa for many years. She is supported by a clinical manager who is a registered nurse and is new to Bupa services. He has previously worked in an aged care in management role. He has been at the service for four months. The Bupa regional manager (RN) also supports the facility manager.

This audit identified improvements required around documentation of interventions, infection control surveillance, scheduled meetings, documentation of the orientation program and maintenance of a complaints register.

**Outcome 1.1: Consumer Rights**

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is clearly visible throughout the facility. Staff and management interviews demonstrate an awareness of consumers' rights and their obligation. Residents/relatives are informed concerning the code of rights. Staff are educated through the training schedule ensuring knowledge of consumer rights. Information on access to advocacy services is provided to residents and relatives on admission. Te Puke has an appointed advocate who visits residents. There are three residents that identify as Maori. Te Puke acknowledges the cultural safety issues for Maori and can manage these on an individual basis.

There are policies and procedures around culture and the delivery of culturally safe services. Residents and family members spoken with showed awareness of their own culture and said this was respected by staff and management in the provision of care. The assessment process is implemented with all residents that incorporate individual’s beliefs, values and spiritual belief systems. This starts with the entry to service where information about culture, beliefs and preferences is recorded. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend this meetings. Family members assist residents to complete ' the map of life'. There is a complaints register that includes complaints, dates, and actions taken but not all complaints are recorded in the register. This requires improvement. Complaints are reported to head office and benchmarked against other facilities.

**Outcome 1.2: Organisational Management**

Te Puke has quality and risk management systems that support the provision of clinical care. Incidents and accidents are reported and immediate follow up is conducted by the registered nurses on duty and investigation is completed by the clinical manager or the facility manager. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Corrective actions are initiated according to benchmarking results. 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. There is a comprehensive health and safety and risk management programme in place.

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**Outcome 1.3: Continuum of Service Delivery**

There is a comprehensive admission pack provided on entry to the service. All residents have a needs assessment prior to admission. 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 orientated and reviewed every six months with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. An improvement is required around the documentation of interventions in care plans to reflect the residents current needs.

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Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. 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 safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with ensuites and are personalised. 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 and a large recreation room. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has ceiling heating in the communal areas and electric panel heaters in the bedrooms.

**Outcome 2: Restraint Minimisation and Safe Practice**

Policies and protocols are congruent with NZS 8134.0. Restraint and enabler training is part of the orientation and included in the in-service education programme. Restraint minimisation and enabler training is provided throughout the year ensuring that all staff complete training. Restraint competencies are current. Staff interview also confirmed on-going training. In the hospital, there are eight restraints (four bedrails and four lap belts) and seven bedrails as an enabler. There is one lap belt as a restraint and no enablers in the rest home. Restraint minimisation procedures are implemented. These procedures include assessment of the least restrictive option, consent, monitoring and evaluation.

**Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.

There is an established and implemented infection control programme. The infection control committee includes a cross section of staff all areas of the service.

The committee and the governing body is responsible for the development of the infection control programme and its review. The facility has access to professional advice within the organisation and has developed close links with the GP's, the local laboratory service, the infection control and public health departments at the local DHB. Infection control matters are also discussed at the quality meetings and staff meetings. Regular audits take place and annual education and toolbox talks are provided for all staff. Benchmarking occurs against other Bupa facilities. Infection rates at Te Puke are below Bupa thresholds. An improvement required around documentation of infection control data.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 45 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 4 | 1 | 0 | 0 |

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

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management  | The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The complaint register 2014 includes six complaints from January to date. The complaint register and complaint benchmarking data sheet do not match. Two complaints are not included in the register and one complaint is acknowledged as received but the compliant letter and follow up documentation are not kept in the complaint folder. On the day of audit, the facility manager was on leave and the management team is unable to locate these documents.  | Ensure that all complaints are recorded on the complaints register and that all information relating to a complaint is kept in the complaint folder.  | 180 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The 2014 meeting schedule was reviewed. Health and safety meetings are scheduled two monthly and had occurred in May and June. Infection control meetings are scheduled two monthly and occurred in January and May. Health and safety meeting are also scheduled two monthly but have only taken place in May and June 2014. RN meetings have also taken place irregularly, there were no meeting minutes January to April 2014 then the meetings commenced for May to June and July.  | Ensure that meetings take place as scheduled.  | 180 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management  | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Staff files reviewed (10) showed that three staff members did not have documented evidence of the orientation program. | Ensure that there is documented evidence of an orientation program which has been signed off on completion.  | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | 1) Resident with two falls in two months has not had a review of falls risk. There are no falls prevention strategies documented in the care plan. 2) There is no review of increased pain levels before and after the commencement of fentanyl patch. 3) There is no documentation of interventions as advised by speech language therapist following resident choking episode. There is no evidence of weekly weighs as written in the long term care plan. 4) There are no documented alternative strategies for de-escalation and management of altered behaviours for two hospital residents.  | Ensure interventions are documented in the care plans and care summaries to reflect the resident’s current needs.  | 90 |
| HDS(IPC)S.2008 | Standard 3.5: Surveillance | Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 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. | PA Low | Review of monthly infection control surveillance data showed that outcome of infections including if an infection is resolved or not are not always documented.  | Ensure that outcome of infections are documented.  | 180 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

The Code is clearly visible throughout the facility. Caregivers and management interviews demonstrate an awareness of consumers' rights and obligation and they have given specific examples that support their understanding of the consumer Code of Rights. Observations of staff and residents interaction during the audit provided examples of ways residents' rights are supported by staff.

Te Puke provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about the Code at induction and through on-going in-service training. Interviews with nine residents (five hospital and four rest home) and three relatives (two hospital and one rest home) confirm the services being provided are in line with the Code.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

Te Puke provides information to residents that include the Code of Rights, complaints and advocacy. Information is given to the family or the enduring power of attorney to read to and/or discuss with the resident. Te Puke provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. Interviews with four rest home residents and five hospital residents confirmed this occurs. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Residents meetings are held and meeting minutes are maintained. Residents raise their concerns in these meetings. The annual satisfaction survey is completed in 2014 and shows overall 73% satisfaction. Advocacy pamphlets are available at main foyer.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission information.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D4.1a Resident files reviewed (nine) showed that cultural and /or spiritual values, individual preferences are identified.

Resident information includes the Bupa vision and values. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process.

Family involvement is actively encouraged through all stages of service delivery and the family/contact pages in the all files reviewed demonstrated this.

Discussions with two unit coordinators confirmed that any beliefs or values are further discussed with family /whanau within three weeks of the admission and incorporated into the care plan. There are a number of multi-cultured residents at Te Puke. The assessment process identifies values and beliefs and staff interviewed gave example of how they incorporated resident’s values and beliefs in to their care.

During the tour of the facility, the respect for privacy and personal space is demonstrated. Interviews with five hospital and four rest home residents confirmed that privacy is ensured.

Discussions with residents (nine) and relatives (three) are positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents' preferred names. Spiritual needs are identified and church services are held each week. There is a policy on abuse and neglect and staff has received training on this.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a Bupa Maori health policy that includes details of links with local Iwi and contact details of tangata whenua who can be accessed as required. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member’s stay/care. There are currently three residents that identify themselves as Maori. One of these files was reviewed and it showed that assessment and care plan identify cultural needs of Maori.

A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e).

Through the admission and assessment process, cultural needs/requirements are identified on an individual basis.

A map of life is completed for all residents and displayed (with verbal consent) either in the resident's room or other visible area. This also assists in identifying the person's cultural values and beliefs.

The policy identifies barriers that may limit Maori access to services. These barriers are minimised through the involvement of external Maori participation. Staff interviews confirm that Maori residents are encouraged to continue with links to whanau, with open access for visiting and opportunities to prepare food specially, stay overnight with the resident or carry out services to suit. Document review showed that Te Puke established a Maori support network in their community. Contact details of support network is documented and made known to staff. This includes the local Maori Minister.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures around culture and the delivery of culturally safe services. These cover respect for individual’s values and beliefs. Staff explained what they understand about culture. Training around cultural safety was last provided in August 2013. Residents and family members spoken with showed awareness of their own culture and said this was respected by staff and management in the provision of care. An extensive assessment process is implemented with all residents that incorporates individual’s beliefs, values and spiritual belief systems. This starts with the entry to service where information about culture, beliefs and preferences is recorded. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Families are invited to attend. Family members assist residents to complete 'the map of life'.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. There are policies and procedures for staff around maintaining professional boundaries. Orientation program covers the Code (link 1.2.7.4.). Position descriptions include responsibilities of the role. Annual staff performance appraisal processes are completed and this is viewed in staff files. Abuse and neglect training was last completed on March 2013. Sexuality and intimacy training was last completed on December 2013.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

A2.2 Services are provided at Te Puke Country Lodge that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

Bupa has a Clinical Nurse Specialist / Nurse Practitioner intern. Her role is primarily based in Auckland, but she is available to other Bupa homes for advice and support. Bupa 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. These newsletters are addressed to individual RNs.

All staff are observed to be very patient and respectful when interacting with residents. Both residents and families interviewed confirmed they are very satisfied with the standard of care provided.

D1.3 All approved service standards are adhered to.

D17.7c There are implemented competencies for care assistants, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The open disclosure policy recognises that residents have a right to full and frank disclosure of information from staff. Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Two unit coordinators (rest home and hospital) and the clinical manager interviewed stated that they record contact with family/whanau on the family/whanau contact record sheet (sighted). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms sampled from May and June 2014 identified on 18 of 18 incident forms that family were informed. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b The three relatives (one from the rest home and two from the hospital) interviewed stated that they are always informed when their family members health status changes.

The interpreter policy includes the contact details of interpreters. A list of Language Lines and government agencies is available. In addition, a number of staff is able to assist with interpreting for care delivery. A policy on contact with media is also available.

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

‘D11.3 The information pack is available in large print and advised that this can be read to residents and this can include any information on negative outcomes or problems experienced in their care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Te Puke has a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are procedure information sheets available including (but not limited to); a) minor skin surgery, b) catheterisation, and c) sub cut fluids. Completed resuscitation treatment plan forms are evident on all nine files reviewed (four hospital and five rest home). General consent forms are evident on nine resident files reviewed. Discussions with six caregivers (two rest home and four hospital) confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Caregivers are observed on the day of audit knocking on resident bedroom doors before entering. 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 medical resuscitation treatment plan and resuscitation advance directive is completed as soon as possible after admission. All resuscitation treatment forms in the nine resident files are signed appropriately by the resident and GP.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Information on access to advocacy services is provided to residents and relatives on admission. The Code of Health and Disability Services Consumer Rights and Advocacy pamphlets are also displayed on at the main foyer. Te Puke has an appointed advocate who visits residents. Interviews with nine residents (five hospital and four rest home) confirm that they are aware of their right to access advocacy. Te Puke has a clear and comprehensive advocacy policy that includes facilitating residents to access support if required or requested. The six caregivers interviewed are conversant with the resident's right to advocacy and support service.

ARC D4.1e. The resident files (nine) include information on resident’s family/whanau and chosen social networks.

D4.1d; Discussions with three family members confirm that Te Puke provides opportunities for the family/EPOA to be involved in decisions

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Links with the community is actively encouraged. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. On the day of the audit, auditors observed that one of the resident was celebrating her 102nd birthday with her family and friends. Activities staff along with the other staff members were organised and participated to this event.

Interviews with nine residents confirmed that the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.

D3.1h. Discussion with nine residents confirmed that they are encouraged to be involved with the service and care. Visiting is actively encouraged. All relatives interviewed (two hospital and one rest home) stated they could visit at any time. Visitors are observed coming and going during the audit.

D3.1.e Discussion with staff and relatives confirmed that residents are supported and encouraged to remain involved in the community and external groups such as churches and the local groups.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a comprehensive policy and procedures to guide staff on how to deal with a complaint. The complaints process and forms are available in the home at the main foyer. The complaints process is compliant with right 10 of the residents' Code of Rights. The six caregivers (two rest home and four hospital) interviewed are able to discuss how they would assist residents or relatives who wish to make a complaint.

The nine residents (four rest home and five hospital) and three relatives (two hospital and one rest home) interviewed stated that they are aware of complaints procedures and comfortable in discussing any concerns with the management team.

The complaints register is not up to date and this is an area requiring improvement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a complaints register that includes complaints, dates, and actions taken but not all complaints included follow up letters. Complaints are reported to head office and benchmarked against other facilities

**Finding:**

The complaint register 2014 includes six complaints from January to date. The complaint register and complaint benchmarking data sheet do not match. Two complaints are not included in the register and one complaint is acknowledged as received but the compliant letter and follow up documentation are not kept in the complaint folder. On the day of audit, the facility manager was on leave and the management team is unable to locate these documents.

**Corrective Action:**

Ensure that all complaints are recorded on the complaints register and that all information relating to a complaint is kept in the complaint folder.

**Timeframe (days):** 180 *(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:**

Te Puke Country Lodge is part of the Bupa group. The service provides hospital and rest home level care for up to 81 residents. On the day of audit, there are 71 residents – 35 at rest home level care and 36 at hospital level care. This includes one resident receiving respite care (hospital level). Since the last audit, the capacity is decreased from 86 to 81. On the day of audit, part of the downstairs rooms were under construction for development of independent living units.

Te Puke was purchased by Bupa Care Homes on 16 September 2013. The transition from a family owned and operated care home to a corporate one has been completed.

Te Puke is managed by an experienced manager, registered nurse (RN) who was on leave on the day of the audit. An interim manager was appointed until the manager returns to work. The interim manager is an experienced manager who has been with Bupa for many years. She is supported by a clinical manager who is a registered nurse and new to Bupa services. He has worked in aged care previously in management role. He has been at the service for four months. The Bupa regional manager (RN) also supports the manager who has been with Bupa for seven years and he oversees 14 Bupa care homes.

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the staff notice board. There is an overall Bupa business plan and risk management plan. Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.

Bupa has robust quality and risk management systems that 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.

The facility manager provides a weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager care homes.

ARC,D17.3di (rest home), D17.4b (hospital), Discussions with the Operations manager confirm that the manager has maintained at least eight hours professional development activities annually, related to managing a hospital.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Te Puke is managed by an experienced manager who is supported by two unit coordinators, the clinical manager and the assistant manager. When the manager is away the assistant manager deputizes. On the day of audit, the operations manager advised that the facility manager was on extended leave therefore Bupa has appointed an interim manager until the manager returns to work.

D19.1a; A review of the documentation, policies and procedures and discussions with staff identified that the service operational management strategies, and quality improvement programme is appropriate to the services provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Te Puke has a quality and risk management system. There are policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There is a master copy of all policies & procedures. These documents have been developed in line with current accepted best and/or evidenced based practice, and are reviewed regularly by Bupa.

Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation; a) there is monthly accident/incident benchmarking reports completed by the clinical manager. He classifies the data collected across the rest home and the hospital and staff incidents/accidents. b) 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. c) Health and safety committee scheduled to meet three monthly and health and safety is also an agenda item at the quality meetings. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa health and safety coordinator. Any serious incidents are reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation. d) The northern regional restraint approval group and the facility restraint group meetings minutes are reviewed. These meetings include a comprehensive review of restraint/enabler use. Restraint internal audit is completed annually.

The monitoring programme 2014 includes (but not limited to); environment hygiene -98% compliance, kitchen 84%, medications 98%, weight management 58% compliance and required corrective actions are identified and implemented. Cleaning 95%, waste and pest control 93%, hazards and work place inspections, 93% and required corrective actions are implemented. Incident and accident audit 80%. Following this audit, required corrective actions are implemented and a staff training occurred around reporting incident and accidents. Food services 90%. Several meetings are held with the cook, and change of food suppliers is also evident as part of the corrective action plan. Activities audit 100%. Clinical file audit 92%. IC audit 93%.

Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected, and corrective actions are required based on benchmarking outcomes. A facility health check audit was completed in May 2014 which measures compliance against the DHB contract and the HDSS. In many areas, required corrective actions are completed and some of them are in progress.

Te Puke has developed a corrective action plan in response to the resident’s satisfaction survey findings regarding food services. Satisfaction survey results showed overall satisfaction around 73%. As part of the quality improvement plan 2014, promotion of residents and family satisfaction is added into the annual quality goals.

Te Puke annual quality goals are mostly around implementation of Bupa system. Progress around the annual quality goals is documented.

Benchmarking reports are generated throughout the year to review performance over a 12 month period. According to benchmarking result, corrective actions are initiated. An example to this is falls. Recoding of tool box talks and changes in work schedule were implemented as a corrective action plan. Another example of corrective action plan is wound care. Wound care procedure is reviewed, and file audits are completed.

As part of the quality and risk management system, there is a meeting schedule but meetings did not take place as scheduled. This is an area requiring improvement.

D19.3: There is a comprehensive health and safety and risk management programme in place. Hazard identification, assessment and management policy guides practice. Bupa also has a health and safety coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2014 that includes two objectives. These are as follows 1) 55% staff feel better because they work for Bupa, 2) maintain sick leave on average below 2%. A review on these goals is in progress.

D19.2g fall 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 by the physiotherapist and sensor mats.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a meeting schedule that includes all meetings. Quality meetings are scheduled two monthly and occurred in January, February, May and June. There is a newsletter to families that include minutes of residents meetings. March, April, May and June newsletters were sighted.

**Finding:**

The 2014 meeting schedule was reviewed. Health and safety meetings are scheduled two monthly and had occurred in May and June. Infection control meetings are scheduled two monthly and occurred in January and May. Health and safety meeting are also scheduled two monthly but have only taken place in May and June 2014. RN meetings have also taken place irregularly, there were no meeting minutes January to April 2014 then the meetings commenced for May to June and July.

**Corrective Action:**

Ensure that meetings take place as scheduled.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Incident forms were reviewed for May and June 2014 relating to falls, wandering, skin tear, bruising, and pressure injuries. Immediate follow up is conducted by the RNs on duty and investigation is completed by the clinical manager or the facility manager. Behaviour assessment and monitoring have been conducted for a resident who was wandering out of the facility. Neurological observations are completed when a resident had a fall with an injury on head. Pressure injuries reported all had new assessment completed, and pressure relieving equipment is provided. There is evidence on other allied health professional involvements such as physiotherapist and geriatrician.

All incident and accidents forms document the follow-up actions taken. Monthly incident/accident analysis is conducted, and results discussed at staff and quality meetings.

18 incident and accident forms reviewed included follow up and open disclosure. Te Puke collects incidents and accidents data on a monthly basis. Discussions with the management confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Examples are given as noro-virus outbreak notification to public health services in March 2014. Following an unexpected death in October 2013, the management had notified the police. Discussions with the interim manager revealed that a copy of the resident’s file has been given to the police and there is no further inquiries made by the Coroner.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

##### 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:** PA Low

**Evidence:**

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development.

There are 91 staff employed by Te Puke Country Lodge, which includes but is not limited to, a manager, an assistant manager, a clinical manager, two unit coordinators, a receptionist, an admin staff, three enrolled nurses, nine RNs, caregiving staff, two activities coordinator, one cook, several kitchen hands, laundry and housekeeping staff, a maintenance person and gardener. Annual practising certificates, including scope of practice, are validated with copies of certificates for RNs and enrolled nurses. A copy of certificates is also maintained for general practitioners.

Ten staff files are selected for review (one clinical manager, two registered nurses, one maintenance, one cook, an activities coordinator and four caregivers). Each staff file audited included evidence of job description, appropriate qualifications, training records and recruitment records and staff competencies. Annual performance appraisals are completed evident in four of 10 staff files - six staff is not due yet.

Bupa has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Ten staff files reviewed showed that three staff members did not have completed orientation documents. This is an area requiring improvement.

Discussion with two unit coordinators and six caregivers confirms that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2014, and the annual training programme exceeds eight hours annually. Attendance records are maintained.

Bupa has a comprehensive annual education schedule and all staff are encouraged to attend. Twenty one caregivers have ACE or Career force qualification in care of elderly. Eight caregivers have current first aid certificates. Five caregivers and eight RNs have completed career force dementia modules. Six caregivers are enrolled in career force training.

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, controlled drug administration, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a comprehensive orientation programme which includes competencies and new staff receive orientation and support with a senior staff member. Two unit coordinators and six caregivers (two rest home and four hospital) interviewed confirmed that this occurs.

**Finding:**

Staff files reviewed (10) showed that three staff members did not have documented evidence of the orientation program.

**Corrective Action:**

Ensure that there is documented evidence of an orientation program which has been signed off on completion.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The wage analysis schedule is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide.

A registered nurse cover on duty 24/7. There are two unit coordinators. The hospital roster includes seven caregivers on the morning shift (including three rest home residents at down stairs), and five staff on in the afternoon and two staff overnight. There is one registered nurse rostered for each shift to cover rest home and hospital residents. Rest home roster includes four caregivers in the morning, three caregivers in the afternoon and two caregiver overnight. There is one additional staff who is rostered 7-11 on both days of weekends. A cook is employed during the day and there are two kitchen hands in the morning and a tea kitchen hand in the evenings. Activities are provided from 09 am until 5.00 pm by two activities coordinators. There is a maintenance person and two laundry staff. There are four house keepers who work 8.30 am to 1 pm on weekdays and one hour cleaning is provided on weekends.

Staff turnover is reported by the operations manager as low. Staffing levels are altered according to resident numbers and acuity. Three relatives (two hospital and one rest home) and nine residents (five hospital and four rest home) interviewed stated that there are sufficient staff on duty. Caregivers interviewed stated that they are well supported by the unit managers and the clinical manager.

##### 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:** FA

**Evidence:**

Resident’s information is entered in to the resident’s file in accurate and timely manner which is appropriate to the service setting. Residents’ records are stored securely in cupboards when not in use. The majority of records are held in paper-based records. Clinical letters and all related specialist documents are retained in the residents file. Summary of InterRAI assessments are printed and kept in the resident’s file.

Most of the resident’s information is integrated in a single file. Medication records are kept in the medication folder and resident admission agreements are held at the office in a separate folder. These information is accessed by the relevant staff.

D7.1: Entries are legible, dated and signed by the relevant caregiver or RN including designation.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a well-developed assessment process, and resident’s needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service. Information gathered at admission is retained in resident’s records. Nine residents (four rest home, five hospital, one) and three relatives (two hospital and one rest home) 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 for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the 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. Where possible the nursing admission assessment is completed to ensure the service can meet the resident’s needs. The unit co-ordinators (rest home and hospital) admit new residents during the week. 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; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

**Attainment and Risk:** FA

**Evidence:**

The service provides for hospital and rest home level of care. There is an admission, assessment and care planning policy.

D.16.2, 3, 4: The nine resident files sampled (four hospital and five rest home) identified that the RNs or unit co-ordinators (RN) complete an initial nursing assessment within 24 hours. Information gathered on admission from the needs assessment, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. Eight of nine files sampled (two hospital and four rest home) identified that the long term support plan is developed within three weeks. One hospital resident is in for respite care and has a short stay nursing assessment and support plan in place. All seven long term care plans sampled are signed and dated by the primary RN. There is documented evidence families are invited to attend the initial care plan meeting and multidisciplinary care plan reviews and GP visits. Families unable to attend meetings have a copy of the care plan mailed to them for input. The activity co-ordinators complete an activity assessment, “Map of Life” and individual activity care plan (section two of the long term support plan) in consultation with the resident/family/whanau as appropriate.

D16.5e: Eight of eight long term resident files sampled identified that the GP had seen the resident within two working days. The respite care resident has a current medical history on file. 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. A GP stamp is used. 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.

The service contracts a GP to provide medical services for the residents. Residents may choose to retain their own GP. The GP visits twice weekly and can be contacted by fax, email and phone. GPs are involved in three monthly multidisciplinary (MDT) reviews and there is documented evidence of GP and family discussions. The GP is available after hours for the service. The GP was unavailable to be interviewed on the day of audit.

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 six caregivers interviewed (two rest home and four hospital) who work across the morning and afternoon shifts state the communication system is good and they receive relevant information at handover to deliver safe and timely cares for the residents.

The geriatrician, hospice and mental health services are readily available as required. A physiotherapist is available by referral.

A podiatrist visits diabetic residents monthly and other residents on request.

Four hospital resident files sampled

Five rest home resident files sampled

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:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Te Puke Country Lodge 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, cultural assessment too and dependency and activities assessments.

Additional risk assessment tools include behaviour, restraint and wound assessments as applicable. Risk assessments are completed on admission and reviewed six monthly as part of the support plan review.

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Service delivery plans (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 eight of nine resident files sampled. One resident is on respite care and has a short stay support plan place. There is a long term 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 and ensuring the care summary (caregivers quick reference guide for delivery of cares) is current (link 1.3.6.1.

Residents (nine) and family members (three) 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. Short term care plans sighted in use included; leg pain, DVT, chest infections and skin tears.

16.3f The nine 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**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. The family members (two hospital and one rest home) confirmed 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.

Six caregivers (two rest home and four hospital) and two RN/unit co-ordinators interviewed state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists (checked June 2013), chair and floor weigh scales (calibrated June 13), transferring equipment, walking frames, wheelchairs, lazy boy chairs on wheels, shower tilting chair and gloves, masks and aprons.

18.3 and 4 Adequate dressing supplies are available. Wound management policies and procedures are in place.

Wound assessment and wound management plans are in place for eight skin tears (seven hospital and one rest home. Short term care plans are in place for skin tears. There is one resident in the rest home with two chronic leg ulcers. There are two residents in the hospital with low grade pressure areas (sacral and toe). Turning charts are in place for pressure area management. Chronic wounds are linked to the care plan. The GP is notified of any non-healing wounds as evidenced in the GP notes. Photos are taken as required.

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 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 available for use that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, blood sugar monitoring, bowel records, continence diary, restraint monitoring and neurological observations.

There is an improvement required around the documentation of interventions to reflect the resident current needs.

##### 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 Moderate

**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. The family member (hospital) confirmed on interview they are notified of any changes to their relative’s health including accident/incidents, infections, GP visits, appointments etc.

**Finding:**

1) Resident with two falls in two months has not had a review of falls risk. There are no falls prevention strategies documented in the care plan. 2) There is no review of increased pain levels before and after the commencement of XXXX. 3) There is no documentation of interventions as advised by speech language therapist following resident XXXX episode. There is no evidence of weekly weighs as written in the long term care plan. 4) There are no documented alternative strategies for de-escalation and management of altered behaviours for two hospital residents.

**Corrective Action:**

Ensure interventions are documented in the care plans and care summaries to reflect the resident’s current needs.

**Timeframe (days):** 90 *(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 two activities co-coordinators who work 37.5 hours per week each from Monday to Friday. The hospital activity co-ordinator has been in the role for seven months, worked as a caregiver previously and has an aged care qualification. The rest home activity co-ordinator has been in the role for the months and has 12 years of previous experience in activities and has an aged care and dementia qualification. Both co-ordinators have a current first aid certificate and attend on-site in services and relevant training. They attend monthly regional diversional therapist meetings. The activity programme is combined for rest home and hospital residents and planned a month in advance which is distributed to the resident rooms. A newsletter is of upcoming events and news is sent to the families. There is a volunteer and Anglican Church visitors who visit the service and spend time reading poetry and newsletters and chatting with residents. There is a large recreational room with an indoor bowls table and space for entertainment. There are lounges in the rest home and hospital, seating alcoves and library room where small group activities and quiet time can be spent with visitors.

Activities include (but not limited to); news and views, sit and be fit, board games, bingo, bowls competition, sing-a-longs, baking, weekly fellowship, choir, crafts and cards. One on one time (hand massage, discussions, wheelchair walks) is spent with residents who are unable to participate or choose not to participate in the activity programme. The service has a van for outings which accommodates six residents and two wheelchair residents. Outings to the community include inter-home visits and competitions, RSA, library, cafes, shopping, garden centres and drives. There are at least three entertainers per month. The men’s group have enjoyed an outing to the aviation centre, outdoor petanque and barbeques. The ladies group enjoy “high tea”, crafts and mother’s day celebrations. Festive occasions and celebrations are held. On the day of audit residents and staff are celebrating a residents 102nd birthday. Residents have been involved in the making of decorations and decorating the hall.

Monthly resident meetings provide an opportunity for feedback and suggestions on the programme, outings and entertainment. Nine residents interviewed (four rest home and five hospital) are very happy with the choice and variety activities offered. 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 activity co-ordinators involved in the multidisciplinary review. Resident individual activity participation registers are 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.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.4a Care plans are evaluated by the primary registered nurse six monthly or when changes to care occur as sighted in six of nine long term resident files sampled. One hospital resident is in for respite care and one hospital and one rest home resident have not been at the service six months. Short term support plans are in place for respite care residents that are reviewed (sighted) on each admission. 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. The multidisciplinary review involves the clinical manager, RN, DT, GP and resident/family. 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. The family members (three) interviewed confirmed 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Referral to other health and disability services is evident in 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 wound nurse, hearing association, haematology, needs assessor, mental health services for the older person, social worker, physiotherapy, dietitian, orthotics, ultrasound and hospital specialists. Health professionals such as Parkinson’s and motor neurone field officers visit residents in the service and offer advice and education as required.

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 rest home to hospital level of care.

D 20.1 Discussion with the clinical manager 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There is a 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.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a rest home and hospital locked medication room with pharmaceutical supplies, controlled drugs safe, clinical equipment and dressing supplies. The supplying pharmacy deliver 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 as sighted on the robotic checking form. Any discrepancies are fed back to the supplying pharmacy. Returns are stored safely in the medication room until collected. All stock and expiry dates are checked. RNs and caregivers who administer medications complete annual medication competency and education. RNs receive support from hospice for palliative care management and syringe driver medications. There are no standing orders in place. There is one self-medicating resident who has had a competency assessment completed by the RN and GP and this is reviewed three monthly. The resident’s robotic rolls is kept in a locked container in the resident’s room. Self-medication is monitored each shift. All eye drops in use in medication trolley are dated on opening. Medication fridge (two) have temperatures recorded daily and these are within acceptable ranges. There are two controlled drug safes (rest home and hospital). Controlled medications in tablet form are dispensed in robotic rolls. Weekly controlled drug checks are completed. RNs complete a controlled drug stocktake at the bottom of each page. There is a pharmacy stocktake six monthly last completed July 2014. There is oxygen and suction equipment available.

Eighteen medication charts were sampled. Controlled drugs are double signed. There is evidence of on-going medication education, audits of medication charts and implementation of corrective actions including signing gaps. PRN medications administered are dated and timed.

Eighteen of 18 medication charts sampled (nine rest home and nine hospital) all have photo identification and allergy status noted. The medication charts are pharmacy generated. All PRN medications have an indication for use.

Eighteen of 18 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bupa policies and procedures are in place. The service employs a head cook and second cook who work a 4 day on 4 day off roster from 9am to 5.30pm. They are supported by morning kitchen hand who prepares breakfast and afternoon kitchen hand to assist with evening meal. The national six weekly menus have been audited and approved by the company 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. The unit co-ordinators meet weekly with the cook to discuss the week’s menu and any dietary needs or changes such as weight loss. A communication book is used between the staff. There is specialised crockery such as lip plates and mugs and utensils 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 diabetic, vegetarian and gluten free bread. There are a number of residents on moulied meals/meats. Meals are served from a bain marie in the rest home and delivered in hot boxes to the hospital dining room. Residents have breakfast in rooms and have a choice of meals in rooms as desired. Cooked food temperatures are checked and recorded for all foods.

There is a well equipped kitchen with a good work flow, separate dishwashing and food preparation/baking areas, external delivery area, walk-in freezers and chiller. Inwards goods are temperature checked on arrival. All foods in the chillers, fridge and freezer are date labelled. There is daily temperature monitoring of fridges and freezers within the kitchen and fridges within the facility. A daily and weekly cleaning duties list is maintained (sighted). The maintenance person undertakes cleaning duties such as walls and ceilings as per the three monthly and six monthly cleaning schedules (sighted). There is a locked chemical cupboard within the kitchen for the storage of chemicals. Staff are observed wearing appropriate personal protective clothing including hats, aprons and gloves.

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 have attended food safety and hygiene training. Staff have attended chemical safety training December 2013.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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 December 2013. All chemicals are clearly labelled with manufacturer’s labels and stored in locked areas. 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building holds a current warrant of fitness which expires on 28 October 2014. The building has two levels with lift access between the floors. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged (next due July 2015). Reactive and preventative maintenance occurs. Repairs and maintenance requests are entered into a log book that is checked daily and signed off as repairs are addressed. There is a 52 week planned maintenance programme in place. All medical equipment was calibrated and is next due in June 2015. There is a full time maintenance person on staff. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. There is on-going maintenance within the facility with refurbishment and replacement of furnishings. The corridors are wide with rails 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 are outdoor courtyards with seating and shade. There is wheelchair access to all areas.
ARC D15.3, The following equipment is available, electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists (checked June 13), chair and floor weigh scales (calibrated June 2013), transferring equipment, walking frames, wheelchairs, lazy boy chairs on wheels, shower tilting chair and gloves, masks and aprons.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms have ensuites. There are adequate communal toilets available. There is appropriate signage with easy clean flooring and fixtures. Privacy locks indicate whether the toilet/shower is vacant or in use. Nine residents interviewed (five hospital, four rest home) 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:** FA

**Evidence:**

The rest home and hospital bedrooms are spacious enough accommodate the residents own furnishings as desired, have tea coffee making facilities and are large enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Six caregivers (two rest home and four hospital) and two RN/unit co-ordinators (interviewed) report that rooms have sufficient space to allow cares to take place. The doors are wide enough for ambulance trolley access. Residents are encouraged to personalise their bedrooms as sighted.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There 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 recreational room with an entertainment area, craft tables and bowls table. 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies including - cleaning department - use of equipment policy and a cleaning schedules in place. There is also a cleaning schedule/methods policy for cleaners. All linen and personal clothing is laundered on site. There is a dedicated laundry person Monday to Sunday for four and a half hours a day. The laundry is well equipped with two commercial washing machines and dryers. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles. There are two entry/exit doors (clean and dirty). Disposable laundry bag inners are used for infectious linen. Laundry staff have attended infection control in-service and chemical safety training. Cleaning schedules are maintained. There are four cleaners who works 8.30 am to 1 pm, Monday to Friday and one hour cleaning is provided over the weekend. Cleaning trolleys are well equipped and are stored in locked cupboards when not in use. Commercial cleaners are contracted for high ceilings and window cleaning. The service has a vax machines for the cleaning of carpets. Cleaners have attended chemical safety. Personal protective equipment is available in the laundry, cleaning and sluice room. Staff are observed to be wearing appropriate protective wear. Nine residents interviewed (five hospital, four rest home) are happy with the laundry and cleaning services provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety occurred 28 Feb 2014. Fire evacuations are held six monthly. There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard. There is an approved evacuation plan dated 24 August 2005. A large store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen and extra blankets are also available.

There is a store cupboard of supplies necessary to manage a pandemic. There are incontinence products and personal protective equipment (PPE) for staff to access in an emergency. Hoists have battery backup. A call bell system is available. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their call bells are answered in a timely manner. All shifts have a trained first-aider. Security policies and procedures are in place. There is a procedure for additional resident supervision to maintain safety.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The facility has ceiling heating throughout communal areas and corridors. There is a gas log fire in the lounge area outside of the dining room in the rest home. Each bedroom has an electric panel that is individually 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, along corridors and in communal areas.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There are documented definitions of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures.

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. Te Puke has an approval process and only staff that have completed a competency assessment are permitted to apply restraints. Restraint minimisation and enabler training is provided throughout the year ensuring that all staff complete training and competencies are current. Staff interview also confirmed on-going training.

Two files reviewed showed that restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of enablers. In the hospital, there are eight restraints (four bedrails and four lap belts) and seven bedrails as an enabler. In the rest home, there is one lab belt as a restraint and there are no enablers. Restraint minimisation procedures are implemented. These procedures include assessment of the least restrictive option, consent, monitoring and evaluation. Restraint minimisation training occurs regularly.

Challenging behaviour training was last completed in May 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Only staff that have completed a competency assessment are permitted to apply restraints. Competency assessments expire annually and are renewed by the restraint coordinator. 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. The restraint co-ordinator is the clinical manager and he has a signed job description and understands the role and her accountabilities and this is confirmed in interview. The assessment and approval process for restraint involves the restraint coordinator, the resident and/or their representative/whanau and the GP.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. The clinical manager is the restraint coordinator. He has a job description in place and signed and dated.

Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment and enabler assessment tool available and completed for the residents requiring restraint for safety. Two files reviewed for restraint minimisation including restraint and enabler showed that the care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified and documented.

The assessment form considered those items listed in 2.2.2.1 (a) - (h) and these aspects were reviewed three 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:**

Te Puke 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 the clinical manager who is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whanau, the GP and the restraint coordinator. Monitoring and observation process is included in the restraint policy. 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 is evaluated.

Meeting minutes and memos to staff include information around safe restraint use and restraint minimisation.

A restraint register is in place, which has been completed for the residents requiring restraint.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred monthly as part of the on-going reassessment for the resident on the restraint register, and as part of their care plan review. The family was included as part of this review. A review of two resident’s files identified that evaluation is up to date. There are evidence of more frequent reviews according to identified risk levels. Review of meeting minutes showed that use of harness as a restraint is discontinued and T-belt restraint is initiated. There is evidence of restraint minimisation and use of less restrictive options of restraint.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Restraint use is individually reviewed at least three monthly through the medical reviews. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of restraint use across the group is discussed at Regional Restraint Approval group which was last held in July 2014. This information is disseminated throughout the organisation. Meeting minutes are sighted.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.

The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. The infection control committee includes a cross section of staff all areas of the service.

The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, the local laboratory service, the infection control and public health departments at the local DHB. Infection control meeting are scheduled two monthly but occurred irregularly (link 1.2.3.6). Infection control matters are also discussed at the quality meetings and staff meetings.

Regular audits are undertaken and these include hand hygiene, infection control practises, laundry and cleaning. Annual education and toolbox talks are provided for all staff.

Staff interviews confirm that staff handover includes information around infection control practices. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control coordinator is the clinical manager and he works closely with the facility manager who has previously undertaken this role. The infection control committee is made up of a cross section of staff from all areas of the service. The facility also has access to public health services, local laboratory, 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:**

There are comprehensive infection control policies that support the Infection Control Standard NZS 8134:3:2008 and they are relevant to the service. 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.

External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator, the infection control committee and expertise from the governing body.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control coordinator is responsible for coordinating/providing education and training to staff. Te Puke can access the infection control nurse, microbiologist, pharmacist, Bug Control, local public health authorities and local laboratory for additional education and support. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was held December 2013 and after the most recent infectious outbreak in March 2014. Resident education is expected to occur as part of providing daily cares. There are two residents with ESBL and staff interview confirmed knowledge around how to manage daily cares of these residents. Care plans include information around reduction of infections as appropriate.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**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. Internal infection control audits also assist the service in evaluating infection control needs. The clinical manager stated that there is close liaison with the GP who advises and provides feedback /information to the service. Benchmarking occurs against other Bupa facilities. Infection rates at Te Puke are below Bupa thresholds. An improvement required around documentation of infection control data.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

**Attainment and Risk:** PA Low

**Evidence:**

Individual infection report forms are completed for all infections. Definitions of infections are appropriate to the complexity of service provided. Infection control data is collated monthly and infections are included on a monthly register. Infection control data reported at the quality, staff and infection control meetings. The surveillance of infection control data is used for evaluating compliance with infection control practices.

**Finding:**

Review of monthly infection control surveillance data showed that outcome of infections including if an infection is resolved or not are not always documented.

**Corrective Action:**

Ensure that outcome of infections are documented.

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