

Bupa Care Services NZ Limited - Stokeswood Rest Home & Hospital

Current Status: 28 July 2014

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

General overview

Stokeswood Rest Home and Hospital is part of the Bupa group. The service is currently certified to provide hospital services (medical and geriatric) and rest home level care for up to 67 residents. On the day of the audit there are 18 of 24 hospital residents and 41 of 43 rest home residents. Stokeswood's facility manager and clinical nurse manager are well qualified for their roles. There are well developed systems, policies and procedures that are structured to provide appropriate care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Stokeswood. A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

A partial provisional audit was completed in June 2014 in respect of a new hospital wing (now occupied) and a dementia unit that continues to be under construction at the time of this surveillance audit.

The service has addressed all six of the shortfalls from the certification audit around meeting minutes, incident reporting, medical review on entry to the service and care planning, medication management and restraint.

The service has addressed five of the ten of the shortfalls from the partial provisional audit around care planning, medication management, building warrant of fitness, fire training and drill. Further improvements continue to be around landscaping and rails outside the hospital, laundry renovation, approved fire evacuation plan and refurbishment of the unoccupied dementia unit.

This audit identified improvements around meeting minutes, interventions and restraint.

Audit Summary as at 28 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 |

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

Consumer Rights as at 28 July 2014

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

Organisational Management as at 28 July 2014

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

Continuum of Service Delivery as at 28 July 2014

| | | |
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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Safe and Appropriate Environment as at 28 July 2014

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Restraint Minimisation and Safe Practice as at 28 July 2014

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|---|--|---|
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Some standards applicable to this service partially attained and of low risk. |
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Infection Prevention and Control as at 28 July 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

| | |
|---|--|
| Legal entity name: | Bupa Care Services NZ Limited |
| Certificate name: | Bupa Care Services NZ Limited - Stokeswood Rest Home & Hospital |
| Designated Auditing Agency: | Health and Disability Auditing New Zealand Limited |
| Types of audit: | Surveillance Audit |
| Premises audited: | Stokeswood Rest Home & Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care) |
| Dates of audit: | Start date: 28 July 2014 End date: 28 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: | 59 |

Audit Team

| | | | | | |
|--------------------------|--------|----------------------------|-----|-----------------------------|---|
| Lead Auditor | XXXXX | Hours on site | 9.5 | Hours off site | 6 |
| Other Auditors | XXXXXX | Total hours on site | 9.5 | Total hours off site | 6 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | XXXXX | | | Hours | 2 |

Sample Totals

| | | | | | |
|--|----|-----------------------------------|----|--------------------------------------|----|
| Total audit hours on site | 19 | Total audit hours off site | 14 | Total audit hours | 33 |
| Number of residents interviewed | 6 | Number of staff interviewed | 10 | Number of managers interviewed | 1 |
| Number of residents' records reviewed | 8 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 70 | Number of relatives interviewed | 1 |
| Number of residents' records reviewed using tracer methodology | 1 | | | Number of GPs interviewed | 0 |

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 | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Tuesday, 19 August 2014

Executive Summary of Audit

General Overview

Stokeswood Rest Home and Hospital is part of the Bupa group. The service is currently certified to provide hospital (medical and geriatric) and rest home level care for up to 67 residents. On the day of the audit there are 18 of 24 hospital residents and 41 of 43 rest home residents. Stokeswood's facility manager and clinical nurse manager are well qualified for their roles. There are well developed systems, policies and procedures that are structured to provide appropriate care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Stokeswood. A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

A partial provisional audit was completed in June 2014 in respect of a new hospital wing – now occupied - and a dementia unit that continues to be under construction at the time of this surveillance audit.

The service has addressed all six of the shortfalls from the certification audit around meeting minutes, incident reporting, medical review on entry to the service and care planning, medication management and restraint.

The service has addressed five of the ten of the shortfalls from the partial provisional audit around care planning, medication management, building warrant of fitness, fire training and drill. Further improvements continue to be around landscaping and rails outside the hospital, laundry renovation, approved fire evacuation plan and refurbishment of the unoccupied dementia unit.

This audit identified improvements around meeting minutes, interventions and restraint.

Outcome 1.1: Consumer Rights

Relatives are kept informed of changes resident health status. Complaints processes are implemented and complaints and concerns are managed and documented.

Outcome 1.2: Organisational Management

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

Outcome 1.3: Continuum of Service Delivery

The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A

registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around the documentation of interventions to reflect the resident's current needs. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed three monthly by the general practitioner. The activities programme is facilitated by a diversional therapist and an activity coordinator. Residents and families report satisfaction with the activities programme. The programme includes community visitors, outings, entertainment and activities that meets the recreational preferences and abilities of the consumers groups. All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans.

Outcome 1.4: Safe and Appropriate Environment

The building holds a current warrant of fitness. Electrical equipment is checked annually. All medical equipment is calibrated and all hoists and electric beds are checked and serviced. Hot water temperatures are monitored monthly and are at 45 degrees and below. There are improvements required around completion of the unoccupied dementia unit, landscaping and railing outside the hospital wings, laundry construction, approved fire service evacuation plan. These shortfalls are outstanding from the recent provisional audit.

Outcome 2: Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has one rest home resident with an enabler in the form of bedrails. The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service currently has four residents in the hospital assessed as using a restraint (three bedrails), two residents with lap belts and one in a fall out chair. A restraint register is in place however this is not current. There are improvements required around restraint monitoring, restraint register and environmental restraint. Restraint use is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities.

Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| Standards | 0 | 12 | 0 | 4 | 2 | 0 | 0 |
| Criteria | 0 | 40 | 0 | 5 | 3 | 0 | 0 |

| | UA Negligible | UA Low | UA Moderate | UA High | UA Critical | Not Applicable | Pending | Not Audited |
|------------------|---------------|--------|-------------|---------|-------------|----------------|---------|-------------|
| Standards | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| Criteria | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 53 |

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|------------|---|---|------------------|
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | a) Complaints are recorded monthly and benchmarked. The monthly data records an on-going HDC complaint each month, and therefore increases the total number of complaints appearing on benchmarking reports, b) the infection control committee meet monthly. The IC meetings do not reflect discussion of all infections (rather only those that go over the | a) Benchmarking data reflects accurate volumes, b) meeting minutes accurately reflect clinical matters. | 90 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--|---|-------------|--|--|------------------|
| | | | | <p>threshold), c) the July IC minutes report a correction to April data, however the correction does not include the skin infection that appears on the monthly report, d) the clinical meetings (held weekly) report against 'infections' – no concerns, although there are on-going infections in the monthly reports, e) the clinical meetings report against 'wound management' – none at present, although there are a range of wounds at the facility.</p> | | |
| 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 | <p>1) There is no size of wound documented for one skin tear and two pressure areas. 2) Pressure area interventions have not been updated on one hospital resident care plan. The pressure area risk assessment has not been reviewed for two hospital residents and one rest home resident who have developed pressure areas (one hospital acquired). 3) One hospital resident</p> | <p>1)Ensure wound size is documented on the wound assessments; 2) Ensure pressure area interventions are documented on care plans care plans; 3) Review pressure area risk assessment tools to reflect current risk; 4) Ensure risks identified with restraint use is identified on the care plan.</p> | 60 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|-------------|--|--|--------------------|
| | | | | with further weight loss has not been referred to the GP as per long term care plan instructions. 4) The risks associated with restraint use is not identified on the care plan of one hospital resident file. | | |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i) The work for the proposed dementia unit has not started yet, therefore the existing building has not been converted to ensure its appropriateness for dementia care. This includes a dining room with a kitchenette and an adjoining lounge. (ii) Some of the windows in the proposed dementia unit have no opening limiters | a) Safety measures are implemented in the design of kitchenette/dining/lounge areas in the dementia unit; b) windows to non-secure areas have opening limiter in the dementia unit. | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Moderate | The concrete ramps are yet to have rails attached and external doors off the hospital wing have been locked for resident safety. | a) landscaping in the external areas (hospital) to be completed; b) railing is completed around ramps outside the hospital areas to avoid locking external doors and preventing external access for residents (link 2.1.4) | 60 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|--|-------------------|---|--|-------------------------|
| HDS(C)S.2008 | Standard 1.4.6: Cleaning And Laundry Services | Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.4.6.3 | Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | PA Low | A small section of the current laundry is under construction to accommodate additional services. The facility manager stated that a commercial washing machine and a commercial dryer will be added to the new laundry. The laundry remains operational and has not been closed during reconstruction. It is estimated work will be complete within the next month. | Complete construction of laundry. | 60 |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.4.7.3 | Where required by legislation there is an approved evacuation plan. | PA Low | A fire service approved evacuation plan has not been received. | Ensure an approval letter has been obtained from the Fire Service to cover both the hospital wing and the renovated dementia unit. | 90 |
| HDS(C)S.2008 | Criterion 1.4.7.6 | The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting. | PA Moderate | The proposed wing provides hospital level care therefore external garden area is not secured and secure doors on entry to the service has not been | External areas and entry to the proposed dementia wing is secured prior to opening. | Prior to occupancy |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|-----------------|--|--|------------|--|---|------------------|
| | | | | placed yet. | | |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Low | | | |
| HDS(RMSP)S.2008 | Criterion 2.1.1.4 | The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | 1) There is no environmental restraint policy in place to evidence; a) the locking of doors do not restrict the normal freedom of residents for whom restraint is not intended b) the use of restraint adheres to the least restrictive practice and the rights, safety and dignity of the resident is upheld and c) the locked doors comply with fire and safety standards. 2) One resident has a fall out chair in use since February 2014 that is not included in the restraint register. 3) Monitoring forms do not identify the restraint being monitored. There is one monitoring form in place for one resident with two restraints | 1) Ensure the use of environmental restraint meets the restraint minimisation and safe practice standard. 2) Ensure the restraint register is current. 3) Ensure restraint monitoring forms identify the type of restraint in use | 90 |

Continuous Improvement (CI) Report

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

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Accident/incident, category ones (i.e., major resident incidents), complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is a specific policy to guide staff on the process to ensure full and frank open disclosure is available. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms reviewed from across 2014 (both service types) identified that family were notified following a resident incident. Incident/accident forms are audited as part of the internal auditing system and a criterion is identified around "incident forms" informing family. The audit was completed in April (2014) confirmed family notification.

At an organisational level, a residents/relatives association was initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician.

Newsletters were in place at Stokeswood. Interpreter policy and contact details of interpreters. A list of Language Lines and Government Agencies is available.

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

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Relative (one hospital) interviewed stated that they are informed when their family members health status changes.

D11.3: The information pack is available in large print and this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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|---|
| Attainment and Risk: FA |
| Evidence: <p>The complaints procedure (065) states 'the facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint management record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with six residents and one relative confirm they were provided with information on complaints. Complaint forms were visible for residents/relatives in various places around the facility.</p> <p>There are 14 recorded complaints between January and June (2014). All complaints were reviewed (including nine that were from residents) and there is well documented investigation, follow up and resolution. There is one complaint from February that came from the Health and Disability Commissioners Office. This complaint</p> |

was closed in May (documents reviewed). Review of the aggregated data shows the HDC complaint has been counted every month since February and this is suggesting the service receives more complaints than they do (link 1.2.3).

D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa Stokeswood provides care for up to 67 residents across two service levels (rest home and hospital). On the day of audit there were 41 of 43 rest home residents and 18 of 24 hospital residents. Stokeswood is in the process of refurbishing the old hospital wing to open a 20 bed dementia unit. At the time of audit this work is still underway. There are no residents under the medical component at the time of audit.

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Stokeswood 2014 quality goals include: facility cleanliness, communication and resolving resident issues. Progress is reported through the quality meetings. Stokeswood annual goals link to the organisations goals and this is reviewed in quality meetings and followed through in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'.

The organisation has commenced a clinical governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) will also be tabled at this forum. Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider has commenced. Stokeswood is part of the central Bupa region which includes eight facilities. The managers in the region teleconference monthly and meet six monthly. A forum is held every six months (with national conference) including all the Bupa managers. Stokeswood is implementing the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care including - knowledgeable staff / meaningful activities / comfortable environment. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans have been implemented since Bupa purchased Stokeswood. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care.

The Bupa CNS provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and dementia care advisor. The newsletter also includes international best practice around dementia care.

The service is managed by an experienced registered nurse who has been the facility manager at Stokeswood since 2011. She has relevant clinical experience including DHB. The clinical nurse manager has been in post since 2008, having previously been a registered nurse at the facility. Support is also provided by the operations manager who visits at least once each month. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical nurse managers attend annual organisational forums and regional forums six monthly.

ARC,D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

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

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

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

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

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

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

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

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| Attainment and Risk: PA Low |
| Evidence: Stokeswood is implementing the Bupa quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team. The service has policies and procedures and implemented systems to provide a good level of assurance that it is meeting accepted |

good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule. Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation. The release is notified by email to all clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the quality meetings at Stokeswood who meet monthly. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical nurse manager that break down the data collected across the rest home and hospital services, and staff incidents/accidents. Incidents are discussed (and recorded) at the monthly qualified staff meeting, full staff meeting and the two monthly quality meetings. The previous finding from the certification audit has been closed.

The service has linked the complaints/compliments process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints/compliments. The aggregated monthly data includes an HDC complaint that was received in February, and not closed out until May. This practice escalates the total number of complaints appearing on benchmarking reports and this is an area of improvement. The Stokeswood infection control committee meet monthly and the weekly reports from the facility manager cover infection control. Infection control is also included as part of benchmarking across the organisation. The IC meetings do not reflect discussion of all infections and this is an area of improvement. There is an organisational regional IC committee. Health and safety committee meets monthly and is also an agenda item at the quality committee with feedback going to staff meetings.

Stokeswood is implementing the Bupa quality and risk management process. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Corrective actions resulting from the internal audit programme were seen to have been closed out. Issues are reported to the appropriate committee e.g. quality.

Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Stokeswood via graphs and benchmarking reports. A monthly summary of each facility within the Operations Managers region is also provided for the Operations Manager which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators and the like throughout the year. A corrective action plan is required when an indicator exceeds the KPI rate by 3.0. Corrective action plans have been developed as prescribed and signed when closed out.

Benchmarking of key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and pressure incidence rates and staff accident and injury rates. Benchmarking of key indicators with another NZ provider has commenced. Benchmarking reports are generated throughout the year to review performance over a 12 month period.

D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury. On-going review of objectives for Stokeswood is seen in H&S meeting minutes.

D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Due to the falls rate at Stokeswood a falls focus group is being established in August (interview clinical manager).

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

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |

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

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

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

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

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

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

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| Attainment and Risk: PA Low |
| Evidence: Key components of the quality management system link to the quality meetings at Stokeswood who meet monthly. There are monthly accident/incident benchmarking reports completed by the clinical nurse manager that break down the data collected across the rest home and hospital services, and staff incidents/accidents. The service has linked the complaints/compliments process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. The Stokeswood infection control committee meet monthly and the weekly reports from the facility manager cover infection control. Clinical meetings occur weekly and a qualified staff meeting monthly. These meetings discuss clinical matters within the service. |
| Finding: a) Complaints are recorded monthly and benchmarked. The monthly data records an on-going HDC complaint each month, and therefore increases the total number of complaints appearing on benchmarking reports, b) the infection control committee meet monthly. The IC meetings do not reflect discussion of all infections (rather only those that go over the threshold), c) the July IC minutes report a correction to April data, however the correction does not include the skin infection that appears on the monthly report, d) the clinical meetings (held weekly) report against 'infections' – no concerns, although there are on-going infections in the monthly reports, e) the clinical |

meetings report against 'wound management' – none at present, although there are a range of wounds at the facility.

Corrective Action:

a) Benchmarking data reflects accurate volumes, b) meeting minutes accurately reflect clinical matters.

Timeframe (days): 90 (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.

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: <p>D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting category one incidents. The completed form is forwarded to the quality and risk team as soon as possible (definitely within 24 hours of the event), even if an investigation is on-going. The certification audit identified incident reporting as an area of high risk. Since the certification audit the following improvements have been implemented: facility manager views all incident reports, discussion about incidents occurs at weekly clinical meetings (minutes sighted) to identify trends, incidents are discussed at other meetings (staff, qualified staff, quality), category 1 incidents have corrective action plans developed (sighted) and are signed off, responsibility for management and oversight by the unit coordinators has been strengthened. As a result of the number of falls a falls focus group is reportedly being established in August (2014).</p> <p>Ten incident forms were reviewed between March and May 2014 (six rest home and four hospital). All forms were completed appropriately, including clinical manager review and sign off. The facility manger could discuss trends and reviews all forms. Neuro observations are completed following unwitnessed falls and any incident involving 'head injury'. Category 1 incidents (two June) have been reported and appear on monthly benchmarking data. Families were reported as having been notified in all reviewed. Five files were reviewed as part of this surveillance audit and events reported in progress notes had an accompanying incident form. Interview with four caregivers and one unit coordinator inform all incidents are reported on the relevant form. The finding from the certification audit is considered to have been met.</p> <p>D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident and the data is linked to the organisation's benchmarking programme and this is used for</p> |

comparative purposes. A corrective action plan is required when an indicator exceeds the KPI rate by 3.0 and are seen to have been completed at Stokeswood.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Register of practising certificates is maintained, both at facility level and website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / links). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (clinical nurse manager, unit coordinator, two caregivers, cook, activities coordinator) and all had personal file checklists. Performance appraisals are current in files reviewed.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time – two buddies were interviewed. Staff interviewed (four caregivers, one unit coordinator) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interview with the clinical nurse manager confirm the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards (sighted in files reviewed). On completion of this orientation they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level three unit standards. These align with Bupa policy and procedures. There is an annual education schedule that is being implemented. There is an RN/enrolled nurse (EN) training day provided through Bupa that covers clinical aspects of care - e.g. wound management. External education is available via the DHB.

Discussion with staff and management confirm a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings. A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a Council approved professional development recognition programme (PDRP). The Nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses.

There is a staff member with a current first aid certificate on every shift.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: <p>There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.</p> <p>There is an RN and first aid trained member of staff on every shift. Interview with four caregivers inform the RN's are supportive and approachable. There is a qualified diversional therapist at the facility.</p> <p>Interviews with staff, residents and relatives inform there are sufficient staff to meet the care needs of the residents.</p> |

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

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

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| Attainment and Risk: FA |
| Evidence: |

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| Attainment and Risk: FA |
| <p>Evidence:</p> <p>Bupa Stokeswood provides rest home and hospital level of care for up to 67 residents. There are 41 rest home residents and 18 hospital level care residents. Two residents on respite care are awaiting approval for rest home care. A registered nurse (RN) undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. This is evident in all five files sampled (three hospital, two rest home). Within three weeks, the long term care plan is developed in five of five files sampled. This is an improvement since the previous audit.</p> <p>In five of five files sampled the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission by the contracted general practitioner (GP) in five files sampled. Six monthly multi-disciplinary reviews (MDR) and meeting minutes completed by the registered nurse are evident in four of five long term resident files. One rest home resident has not been at the service long enough for a six monthly review. Input is sought from the caregivers, the GP, the activity coordinators and any other relevant person such as the physiotherapist. The MDR checklist identifies the family member who has attended the MDR review.</p> <p>Six residents interviewed (five rest home and one hospital) stated that they and their family are involved in planning their care plan and at evaluation. Resident files included family/whanau contact records, which are completed and up to date in the five resident files sampled (two rest home, three hospital).</p> <p>Five resident files reviewed identified that the GP had seen the resident within two working days. This is an improvement since the previous partial provisional audit. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The GP visits weekly and is involved in the six monthly reviews. The GP is unavailable for interview on the day of audit.</p> <p>Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. There are written handover sheets that cover each shift and identify mobility status for each resident and any significant events that have occurred such as falls, infections and changes to health. Progress notes are written on each shift, dated, timed, and signed with designation. RN entries are also identified with a "nursing" stamp. This is an improvement since the previous audit. Five files</p> |

(two rest home, three hospital) identified integration of allied health and a team approach is evident in the five files. The service contracts a physiotherapist for 1.5 hours per week. Physiotherapy assessments and transfer plans are completed by the physiotherapy with follow-ups for any residents with falls.

Tracer methodology rest home:

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

Tracer methodology hospital resident

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| 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.

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

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

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 1.3.6: 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:

The registered nurses complete residents' care plans. A care summary is also readily available for caregivers to access. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The four caregivers interviewed (two hospital and two rest home) and hospital unit co-ordinator stated that they have all the equipment referred to in care plans and necessary to provide care, including hoists (checked June 2014), chair scales (new), wheelchairs, electric beds, lazy boy chairs on wheels, sensor mats, mobility aids, continence supplies, dressing supplies and any miscellaneous items. Six residents and a family member interviewed are complimentary of care received at the facility. The care being provided is consistent with the needs of residents; this is evidenced by discussions with caregivers, registered nurse and the clinical manager.

Dressing supplies are available and a treatment room is stocked for use. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Residents with indwelling catheter have a catheter management plan and catheter change record on file. Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 22 wounds; 11 skin tears, five minor wounds, leg ulcer, four sacral pressure areas and two heel pressure areas in the hospital wing and three skin tears, and one surgical wound in the rest home wing. Photos are taken as required and there is evidence of wound nurse specialist input for chronic wounds. There is an improvement required around wound and pressure area documentation. The clinical manager and unit co-ordinator interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

There is a physiotherapist contracted for 1.5 hours per week who undertakes an initial physiotherapy assessment and transfer plans for all residents. The physiotherapist

follows up residents post falls and is involved in multidisciplinary reviews.

The RN completes risk tool assessments on admission including cultural assessment, continence, falls, skin, pressure area, nutritional assessments, pain assessments, cultural assessment, dependency rating, wound and restraint assessment as applicable.

Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, food and intake record, two hourly turning chart, Iowa pain monitoring tool and behaviour monitoring. There is an improvement required around weight loss management. Residents interviewed confirm their needs are being met.

During the tour of facility, it was noted that all staff treated residents with respect and dignity, and residents and families were able to confirm this observation

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

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

Attainment and Risk: PA Moderate

Evidence:

When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Wound assessment and wound management plans are in place for 22 wounds; 11 skin tears, five minor wounds, leg ulcer, four sacral pressure areas and two heel pressure areas in the hospital wing and three skin tears, and one surgical wound in the rest home wing. Photos are taken as required and there is evidence of wound nurse specialist input for chronic wounds. The RN completes risk tool assessments on admission including cultural assessment, continence, falls, skin, pressure area, nutritional assessments, pain assessments, cultural assessment, dependency rating, wound and restraint assessment as applicable

Finding:

1) There is no size of wound documented for one skin tear and two pressure areas. 2) Pressure area interventions have not been updated on one hospital resident care plan. The pressure area risk assessment has not been reviewed for two hospital residents and one rest home resident who have developed pressure areas (one hospital acquired). 3) One hospital resident with further weight loss has not been referred to the GP as per long term care plan instructions. 4) The risks associated with restraint use are not identified on the care plan of one hospital resident file.

Corrective Action:

1) Ensure wound size is documented on the wound assessments; 2) Ensure pressure area interventions are documented on care plans care plans; 3) Review pressure area risk assessment tools to reflect current risk; 4) Ensure risks identified with restraint use is identified on the care plan.

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

Standard 1.3.7: 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:

There are two activity co-ordinators employed for 27 hours per week each. One is qualified diversional therapist (DT) and the other activity co-ordinator has completed dementia units. They have current first aid certificates and attend the Bupa regional DT workshops and Wellington support group as well as attending on-site in-services.

The activity programme is implemented Monday to Friday with activities occurring in either the rest home or hospital lounges. The activities are open to all residents. One on one individual time is spent with residents who choose not to participate in the programme or unable to participate in group activities. The development of the programme involves the residents and reflects their interests and hobbies. The activity programme “flyer” is delivered to resident rooms, available in large print and displayed throughout the facility.

The activity programme includes (but not limited to): indoor bowls, exercise, news, housie, music, skittles, quizzes, crosswords, stories, ten pin bowling, tables’ games, DVDs, hobbies group and Happy Hours. Ladies enjoy a pamper parlour and men have outings to “the shed”. Community volunteers (two) are involved in the implementation of the programme and spend time chatting with residents. Other community visitors include schools, library, canine friends, kindergarten children, mothers and babies. Events, birthdays, festive occasions and multicultural festivals are celebrated. There are church services weekly with weekly catholic communion. Entertainers are on-site weekly. The service has a van and activity co-ordinators have completed a van competency. There are regular outings at least weekly which include scenic drives, inter-home visits and competitions, community hall visits with afternoon teas and shopping.

The family/resident completes a Map of Life on admission which includes previous hobbies, community links, family, and interests. The individual activity plan in all resident files sampled (three hospital, two rest home) identify activities and community links that reflect the resident’s normal patterns of life.

Five resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review.

Residents have the opportunity to provide feedback on the activity programme through the six weekly resident meeting that is taken by the Minister (resident advocate) and resident satisfaction surveys.

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:

Support plans are reviewed and evaluated by the registered nurse at least six monthly in four (two rest home, two hospital) of five files sampled. One rest home resident has not been at the service six months. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from

caregivers, the GP, the activity coordinators and any other relevant person such as the physiotherapist. The multi-disciplinary review (MDR) checklist identifies the family member who has attended the MDR review. The long term care plan is updated with any changes to care resulting from the six monthly evaluation or earlier as required. This is an improvement from the previous audit.

There is at least a three monthly medical review by the medical practitioner.

There are short-term care plans available to focus on acute and short-term issues. Short term care plans in place sighted are for fall, weight loss and pressure area.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

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

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

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

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

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:

Medications are managed appropriately in line with accepted guidelines. The medications for the rest home are stored in a locked trolley in the key padded nurse's office in the rest home area. The controlled drug safe is kept in the hospital medication room. Regular medications are dispensed in robotics and checked on delivery by an RN. Short courses and as required (PRN) medications are in blister packs. All medications are signed on the pack when checked. Discrepancies are fed back to the supplying pharmacy. Expiry dates of PRNs, antibiotic supplies and pharmaceutical supplies are checked monthly and dates recorded. Registered nurses, enrolled nurses and senior caregivers in the rest home who administer medications have completed annual medication competencies and attended annual education sessions. RNs have completed syringe driver courses. Controlled drugs in the hospital controlled drug safe are checked weekly. Administration of controlled drugs are signed by two medication competent staff one of whom is an RN. A pharmacy audit is completed six monthly in June and December each year. GP standing orders are current. An antibiotic stock is kept in the hospital unit for GP prescribing after hours. The hospital wing holds a palliative care and controlled drugs stick. All eye drops in use are dated on opening. Medication fridge temperatures are monitored daily with evidence of corrective action for temperatures outside of the acceptable range. Oxygen and suction is available and checked daily. There is currently one rest home resident self-administering. There is a self-medication assessment that is reviewed three monthly. The medication chart identifies the medications self-administered and signed on the signing sheet. All PRN medication administered are dated and timed. Signing sheets correspond to instructions on the medication chart. There are no gaps on the signing sheet. This is an improvement since the previous partial provisional audit. The medication folder contains infection data and wound infection log, pharmacy updates and information on medication interactions and approved abbreviations. Residents on pain relief have an IOWA pain monitoring form in the medication folder. Residents on antipsychotics have an antipsychotic medication management plan in place. The midday medication round observed in the hospital dining room evidenced compliance of medication administration. Ten medication profiles sampled are pharmacy generated, legible, and up to date and reviewed at least three monthly by the G.P. There are photos (dated) and allergy status documented on all 10 medication charts sampled.

D16.5.e.i.2; 10 medication charts reviewed (five rest home and five hospital) identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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.

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| 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.

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| Attainment and Risk: FA |
| Evidence: |

Finding:

Corrective Action:

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

Standard 1.3.13: 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:

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'.

The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site. Resident likes and dislikes are known and alternative choices offered. The residents have a nutrition and dietary profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Special diets are noted on the kitchen whiteboard, which can be viewed only by kitchen staff. Special diets being catered for include normal, diabetic, pureed diets, thickened fluids, low salt and vegetarian. Lip plates and specialised drinking cups and utensils are provided to promote and maintain independence with meals. Staff are observed sitting beside hospital residents assisting and feeding them as required. Meals are served from bain maries to the residents in the rest home dining room and hospital dining room.

The chef receives written notification for any dietary changes or requirements. The chef holds City and Guilds qualifications. He is supported by morning and afternoon kitchen hands that have completed food safety and hygiene training.

The service has a large workable kitchen that contains a pantry, freezer, fridges, gas hobs and oven, combi-oven, bain marie, deep fryer, microwave and commercial baking equipment. All equipment is checked annually. Hot food temperatures are monitored on all meals daily (records sighted). Fridges and freezers have temperatures monitored daily. The fire extinguisher and fire blanket have been checked within the last year. There is a locked chemical cupboard within the kitchen.

Residents have the opportunity to feedback on the meals and provide suggestions at the resident meetings. The resident annual satisfaction survey includes food.

There are a number of audits completed including; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit..

There is a kitchen manual that includes (but is not limited to) hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety.

Staff have been trained in safe food handling and chemical safety.

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

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The occupied area (rest home and hospital) have been built to comply with legislation and all required equipment is in place. The nurse's station look out on the open plan dining and lounge areas, which ensures that staff are in close contact with residents even when attending to paper work or meetings. Residents are able to bring their own possessions into the home and are able to adorn their room as desired (sighted). There are handrails in en-suites and hallways. All rooms and communal areas allow for safe use of mobility equipment. The facility has carpet throughout with vinyl surfaces in bathrooms/toilets and kitchen areas. There is adequate space for storage of mobility equipment. The maintenance schedule includes checking of equipment. All electrical equipment and other machinery are checked as part of the annual maintenance and verification checks with the call bell system. The work for the proposed dementia unit continues to be underway (unoccupied). A current building warrant of fitness has been obtained (30/06/2014) and hot water temperature monitoring for the hospital wing is included in the monthly monitoring schedule, the finding from the partial provisional audit has been met. Landscaping and rails around external ramps requires completion, and recommendations in respect of the dementia unit remain areas for improvement.

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: PA Low

Evidence:

The refurbishment of the hospital to become a new dementia unit is still in the process of being completed.

Finding:

(i) The work for the proposed dementia unit has not started yet, therefore the existing building has not been converted to ensure its appropriateness for dementia care. This includes a dining room with a kitchenette and an adjoining lounge. (ii) Some of the windows in the proposed dementia unit have no opening limiters

Corrective Action:

a) Safety measures are implemented in the design of kitchenette/dining/lounge areas in the dementia unit; b) windows to non-secure areas have opening limiter in the dementia unit.

Timeframe (days): Prior to occupancy (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: PA Moderate

Evidence:

External areas are in the process of being landscaped including access through the dining lounge area and around the building. Landscaping also required for the proposed dementia wing (yet to commence).

Finding:

The concrete ramps are yet to have rails attached and external doors off the hospital wing have been locked for resident safety.

Corrective Action:

a) landscaping in the external areas (hospital) to be completed; b) railing is completed around ramps outside the hospital areas to avoid locking external doors and preventing external access for residents (link 2.1.4)

Timeframe (days): 60 (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: PA Low

Evidence:

There are laundry and cleaning policies and procedures. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. The service has completed internal audits of its laundry and cleaning services. There is a secure area for the storage of cleaning and laundry chemicals. All chemicals are labelled. Material safety data sheets are available for staff. Personal protective equipment are available. Current laundry is under construction and this continues to be an area for improvement.

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: PA Low

Evidence:

There is a secure sluice room in the new wing with a sanitizer. The proposed dementia wing already have a sluice room for the disposal of soiled water or waste.

Finding:

A small section of the current laundry is under construction to accommodate additional services. The facility manager stated that a commercial washing machine and a commercial dryer will be added to the new laundry. The laundry remains operational and has not been closed during reconstruction. It is estimated work will be complete within the next month.

Corrective Action:

Complete construction of laundry.

Timeframe (days): 60 (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: PA Low

Evidence:

There is a comprehensive civil defence manual and emergency procedure manual in place. There is emergency lighting and alternative cooking facilities are available. There is a store cupboard of supplies necessary to manage a pandemic. Appropriate training, information, and equipment for responding to emergencies are provided. The facility manager stated that there are large water tanks available in the ceiling space. Staff training in fire safety occurs six monthly and the last completed 22/7/14, the finding from the provisional audit has now been met. Noting once the dementia unit is operational training and a drill should be undertaken to ensure effective management with the additional resident numbers. There is at least one staff member with a current first aid certificate per shift. Call bells are available in all resident areas that is, bedrooms, en-suite toilet/showers, communal toilets, dining/rooms. Residents, staff and families continue to use the front entry to Stokeswood and there are no changes required for the security of the building (link 2.1.4). However the proposed dementia wing do not have security doors in place and garden area is not secured yet. The fire evacuation plan has yet to be signed off as approved by the NZ fire service.

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.

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| Attainment and Risk: PA Low |
| Evidence: Smoke alarms, sprinkler system and exit signs are in place in the building. The fire evacuation plan has yet to be signed off as approved by the NZ fire service |
| Finding: A fire service approved evacuation plan has not been received. |
| Corrective Action: Ensure an approval letter has been obtained from the Fire Service to cover both the hospital wing and the renovated dementia unit. |
| Timeframe (days): 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |

Corrective Action:

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

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: PA Moderate

Evidence:

The proposed dementia unit has external areas that can be secured and there is plan where the secure doors to be placed on entry to the service

Finding:

The proposed wing provides hospital level care therefore external garden area is not secured and secure doors on entry to the service has not been placed yet.

Corrective Action:

External areas and entry to the proposed dementia wing is secured prior to opening.

Timeframe (days): Prior to occupancy (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: PA Low

Evidence:

Restraint policy (251) states the organisations philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however we acknowledge that there may be occasions when a

resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated'. There is a regional restraint group at an organisation level that reviews restraint practices. Meeting minutes are sighted for July 2014. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. Restraint/enablers are also discussed in the quality meetings, clinical meetings and full staff meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.

The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has one rest home resident on the register with an enabler in the form of bedrails. The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service has four residents in the hospital wing using bedrails as restraints. One resident has a fall out chair in use since February 2014 and this is not included in the restraint register. Two of the residents also have lap belts in place as restraints. Enablers are reviewed six monthly and restraints are reviewed three monthly.

Assessments (including risks and benefits to the resident) are completed for enabler and restraint use (link 1.3.6.1). Monitoring forms are in place that identify the time on and off of restraint, cares delivered during the restraint period and safety checks. Monitoring forms do not identify the restraint being monitored.

Environmental restraint is being used in the new hospital wing with two external doors being locked. One door has a push button exit and this button is out of reach of residents. The other door has keypad door exit however the code is not displayed or known to the residents. Currently the doors are being kept locked while awaiting safety rails on the outdoor patios. There is no environmental restraint policy in place to evidence a) the locking of doors do not restrict the normal freedom of residents for whom restraint is not intended b) the use of restraint adheres to the least restrictive practice and the rights, safety and dignity of the resident is upheld and c) the locked doors comply with fire and safety standards.

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: PA Low

Evidence:

Environmental restraint is being used in the new hospital wing with two doors being locked. One door has a push button exit and this button is out of reach of residents. The other door has keypad door exit however the code is not displayed or known to the residents. Currently the doors are being kept locked while awaiting safety rails on the outdoor patios.

Currently the service has one rest home resident on the register with an enabler in the form of bedrails. The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service has four residents in the hospital wing bedrails.

Monitoring forms are in place that identify the time on and off of restraint, care delivered during the restraint period and safety checks.

Finding:

1) There is no environmental restraint policy in place to evidence; a) the locking of doors do not restrict the normal freedom of residents for whom restraint is not intended b) the use of restraint adheres to the least restrictive practice and the rights, safety and dignity of the resident is upheld and c) the locked doors comply with fire and safety standards. 2) One resident has a fall out chair in use since February 2014 that is not included in the restraint register. 3) Monitoring forms do not identify the restraint being monitored. There is one monitoring form in place for one resident with two restraints

Corrective Action:

1) Ensure the use of environmental restraint meets the restraint minimisation and safe practice standard. 2) Ensure the restraint register is current. 3) Ensure restraint monitoring forms identify the type of restraint in use

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings (link 1.2.3). The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the facility manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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