

Bupa Care Services NZ Limited - Hayman Care Home

CURRENT STATUS: 26-Aug-13

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

GENERAL OVERVIEW

Hayman Rest Home and Hospital is part of the Bupa Care Services (Bupa) group. The service is certified to provide hospital (geriatric and medical), rest home, dementia level care and residential disability care - physical and intellectual. The service has a capacity of 87 residents. On the day of the audit there were 29 hospital residents, 16 rest home residents and 34 residents across the two dementia units. Hayman is managed by an experienced aged care registered nurse, who is new to the role. She is also supported by a clinical manager, three unit coordinators and a Bupa operations manager. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to Hayman. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

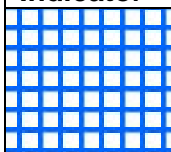
As part of this audit, a verification was completed to assess five rooms currently being used as rest home level rooms as suitable to be used as part of one of the dementia units. There are two improvements required in regards to the verification related to ensuring the extra rooms are secure within the unit and ensuring there is adequate space in the living/area.

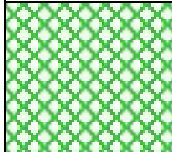
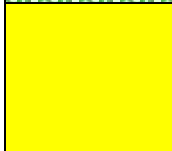


The service is commended for achieving two continual improvement ratings relating to cultural support and quality goals/governance. Improvements are required related to complaints, signing documents, aspects of care planning interventions, medication documentation and fridge temperature monitoring.

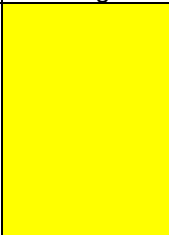
AUDIT SUMMARY AS AT 26-AUG-13

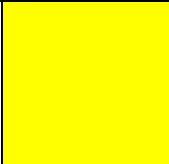
Standards have been assessed and summarised below:

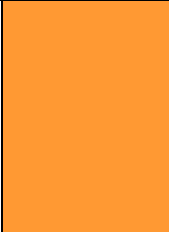
Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded

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

Consumer Rights	Day of Audit 26-Aug-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk

Organisational Management	Day of Audit 26-Aug-13	Assessment
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	Day of Audit 26-Aug-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Safe and Appropriate Environment	Day of Audit 26-Aug-13	Assessment
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

Restraint Minimisation and Safe Practice	Day of Audit 26-Aug-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained

Infection Prevention and Control	Day of Audit 26-Aug-13	Assessment
Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained

AUDIT RESULTS AS AT 26-AUG-13

Consumer Rights

Hayman endeavours to provide care in a way that focuses on the individual residents' quality of life. Bupa has introduced an initiative "personal best" whereby staff undertake a project to benefit or enhance the life of a resident(s). Hayman have a number of staff involved in the programme. Residents and relatives spoke positively about care provided at Hayman. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. There is an

improvement required around documented all complaints. Residents and family interviewed verified on-going involvement with community.

Organisational Management

Hayman has an established 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 also to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Hayman is benchmarked in three of these (rest home, dementia and hospital). Benchmarking and audit data demonstrate that they have achieved good standards of care and service. Quality actions have resulted in a number of quality improvements for both residents and staff. There is an active health and safety committee. 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 a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering. There is an improvement required around signing and dating all documents.

Continuum of Service Delivery

The service has an admission policy and process. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, interventions, 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 care planning, two hourly turns and wound management.

Medicines are managed and policies reflect legislative requirements. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There are improvements required around signing sheet documentation and medication chart reviews.

The activities programme is facilitated by two activities coordinators. There is a separate programme for the rest home/hospital and the dementia unit. The individual needs of younger residents are well catered for. The activities programme provides varied options and activities are enjoyed by the residents. Each resident has a comprehensive individualised plan. Community activities are encouraged, van outings are arranged on a regular basis.

All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietician. There is an improvement required around fridge temperature monitoring.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Appropriate legislative requirements are met and protective equipment and clothing is provided and used by staff. The service documentation provides evidence there are appropriate systems in place to ensure the residents physical environment and facilities are fit for their purpose. There is a current building warrant of fitness. This audit has assessed five rooms [currently used by rest home residents] to be included in the Te Rangi Marie dementia unit. Two improvements are required before this change occurs around securing the area and extending the dining room and lounge as planned.

Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. Documented systems are in place for essential, emergency and security services. Staff interviews detailed current training in relevant areas. There are alternative energy and utility sources are maintained and security systems are in place. A staff with a current first aid certificate is always on duty. The home is warm and bedrooms personalised. Maintenance is routinely carried out by the service.

Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service remains restraint and enabler-free. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training and is supported by the Bupa quality and risk team. Infection control training is provided at least twice each year for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

Hayman Rest Home & Hospital

Bupa Care Services NZ Limited

Certification audit & Verification audit - Audit Report

Audit Date: 26-Aug-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXX	RCompN, Health audit cert	16.00	7.00	26-Aug-13 to 27-Aug-13
Auditor 1	XXXXXXX	RCompN, Health audit cert	16.00	6.00	26-Aug-13 to 27-Aug-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXX			1.00	

Total Audit Hours on site	32.00	Total Audit Hours off site <i>(system generated)</i>	14.00	Total Audit Hours	46.00
Staff Records Reviewed	10 of 85	Client Records Reviewed <i>(numeric)</i>	9 of 79	Number of Client Records Reviewed using Tracer Methodology	4 of 9

Staff Interviewed	22 of 85	Management Interviewed <i>(numeric)</i>	2 of 2	Relatives Interviewed <i>(numeric)</i>	6
Consumers Interviewed	9 of 79	Number of Medication Records Reviewed	18 of 79	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) 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 Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 26 day of September 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit:

The audit summary has been developed in consultation with the provider:

Electronic Sign Off from a DAA delegated authority (*click here*):

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Hayman Rest Home & Hospital	87	79		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

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1.4 Safe and Appropriate Environment

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2 Restraint Minimisation and Safe Practice

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3. Infection Prevention and Control

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Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	FA	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	FA	0	2	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	FA	0	4	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	FA	0	3	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	CI	1	0	0	0	0	2
Standard 1.1.7	Discrimination	FA	0	1	0	0	0	5
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	FA	0	3	0	0	0	9
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	FA	0	2	0	0	0	2
Standard 1.1.13	Complaints management	PA Low	0	1	1	0	0	3

Consumer Rights Standards (of 12):	N/A:0	CI:1	FA: 10	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:1	FA:21	PA:1	UA:0	NA: 0			

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	CI	1	1	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	FA	0	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	0	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	PA Low	0	3	1	0	0	10

Organisational Management Standards (of 7):	N/A:0	CI:1	FA: 5	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:1	FA:20	PA:1	UA:0	NA: 0		

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	1	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	FA	0	1	0	0	0	5
Standard 1.3.5	Planning	PA Low	0	1	1	0	0	5
Standard 1.3.6	Service delivery / interventions	PA Moderate	0	0	1	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	PA Low	0	2	1	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 8	PA Neg: 0	PA Low: 2	PA Mod: 2	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:17	PA:4	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances	FA	0	2	0	0	0	6
Standard 1.4.2	Facility specifications	PA Moderate	0	2	1	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	FA	0	1	0	0	0	5
Standard 1.4.4	Personal space/bed areas	FA	0	1	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining	PA Low	0	0	1	0	0	3
Standard 1.4.6	Cleaning and laundry services	FA	0	2	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	FA	0	5	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	FA	0	2	0	0	0	3

Safe and Appropriate Environment Standards (of 8):	N/A:0	CI:0	FA: 6	PA Neg: 0	PA Low: 1	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 36):	CI:0	FA:15	PA:2	UA:0	NA: 0		

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	1	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	1	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	3	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	2	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	1	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 5	CI:0	FA: 1	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 21):	CI:0	FA:1	PA:0	UA:0	NA: 8		

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	FA	0	3	0	0	0	9
Standard 3.2	Implementing the infection control programme	FA	0	1	0	0	0	4
Standard 3.3	Policies and procedures	FA	0	1	0	0	0	3
Standard 3.4	Education	FA	0	2	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5):								N/A: 0	CI:0	FA: 5	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
								PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 29):	CI:0	FA:9	PA:0	UA:0	NA: 0									

Total Standards (of 50)	N/A: 5	CI: 2	FA: 35	PA Neg: 0	PA Low: 5	PA Mod: 3	PA High: 0	PA Crit: 0	UA
Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 2	FA: 83	PA: 8	UA: 0	N/A: 8				

Corrective Action Requests (CAR) Report

Provider Name: Bupa Care Services NZ Limited
 Type of Audit: Certification audit
 Verification audit

Date(s) of Audit Report: Start Date:26-Aug-13 End Date: 27-Aug-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.13	1.1.13.3	PA Low	<p>Finding: Two relatives interviewed stated they had made complaints via emails and that these were well managed and addressed. However, it was noted that these were not all included as part of the complaints register and consequent follow up documentation identified.</p> <p>Action: Ensure concerns/complaints brought up by family via email or verbally are included as part of the complaints management system</p>	6 months
1.2.9	1.2.9.9	PA Low	<p>Finding: Incident forms reviewed for August were thoroughly completed, however a number of different staff were noted to have documented on the incident form particularly in relation to clinical assessment and follow up post-incident. Not all entries were signed and dated and therefore difficult to determine who the writer was and when it was documented.</p> <p>Action: Ensure all entries on incident forms are signed and dated.</p>	6 months
1.3.5	1.3.5.2	PA Low	<p>Finding: Three of nine resident files do not include interventions for all identified needs. Examples include seizure management, pain management and falls management.</p> <p>Action: Ensure all identified needs have corresponding interventions in the care plans.</p>	3 months
1.3.6	1.3.6.1	PA	<p>Finding:</p>	3 months

		Moderate	<p>(i) One file sampled is for a resident requiring two hourly turns. The turning charts evidences that the turns have not occurred two hourly. The sample was increased to include a further two hourly turning charts and both indicate that the residents have not been turned two hourly. (ii) Nine of 19 wounds have not been reviewed in the stated timeframe.</p> <p>Action:</p> <p>(i) Ensure two hourly turns are completed as required and these are documented. (ii) Ensure all wounds are reviewed within stated timeframes.</p>	
1.3.12	1.3.12.1	PA Moderate	<p>Finding:</p> <p>(i) Two of 18 medication charts sampled have not been reviewed in the past three months. (ii) Two of 18 medication administration signing sheets show that medication has been signed as administered that is not prescribed. (iii) Fifteen of 18 medication signing sheets have medication that is charted as regular but has not been signed as administered regularly.</p> <p>Action:</p> <p>(i) Ensure all medication charts are reviewed at least three monthly. (ii) and (iii) Ensure all medication is administered as prescribed.</p>	3 months
1.3.13	1.3.13.5	PA Low	<p>Finding:</p> <p>There is one fridge in the hospital lounge which has consistently been recorded (incorrectly) at 77 degrees with no corrective action undertaken.</p> <p>Action:</p> <p>Ensure all fridges are maintained at a safe temperature.</p>	6 months
1.4.2	1.4.2.4	PA Low	<p>Finding:</p> <p>The extra five beds being assessed as suitable for an addition to the dementia unit do not yet have a keypad on the door to make the area secure.</p> <p>Action:</p> <p>Ensure the new wing being added to the dementia unit has a secure door.</p>	Prior to use of the extension in the dementia unit.
1.4.5	1.4.5.1	PA Low	<p>Finding:</p> <p>The lounge and dining room in the Te Rangī Marie dementia unit, which is being assessed to include five extra beds is not of sufficient size to accommodate an extra five residents. There are plans in place to extend the lounge and dining room in the Te Rangī Marie area.</p> <p>Action:</p> <p>Ensure there is sufficient space in communal areas to accommodate all residents in Te Rangī</p>	Prior to use of the extension in the dementia unit.

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Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Verification audit

Date(s) of Audit Report: Start Date:26-Aug-13 End Date: 27-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Evidence
1.1.6	1.1.6.2	<p>Finding:</p> <p>Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member's stay/care. The service identified that with the increase in Maori residents to 25%, the development of a Kaiarahi Uaara role was very important. The management team and Kaiarahi Uaara interviewed stated the role has been successful with the Kaiarahi Uaara liaising between Maori residents and their families and providing information and reassurance around coming into care. Part of this has included filming for a dvd to answer questions Maori may have regarding care homes. A Kawanta has also been developed between Hayman Care Home and Manurewa Marae. The Food for Thought Committee which includes qualified dietitian. The service is multi-cultural and staff, resident and relatives interviewed informing a range of alternatives are offered to meet particular cultural needs - e.g. halal options, Dahl and boil-ups. The varied menu reflecting the diversity of the cultures at Hayman Home and hospital. Residents are offered rice daily as an alternative accompaniment if they wish. The service has also developed a Hayman Dementia think tank group which involves clinical and activities staff as well as invited guests. This group has become a finalist in the Westpac Auckland South Business Awards 2013. Meeting minutes include discussion of specific residents with behaviours that challenge and consider cultural needs when managing. Interviews with 10 caregivers identified that a number of residents speak different language and there are a number of staff that can speak the many languages at Hayman. Family interviewed confirmed that the service goes out of their way to ensure cultural, values and beliefs are identified and the monthly resident/family forum is also a great opportunity to share specific ways they could meet specific needs.</p>

1.2.1	1.2.1.1	<p>Finding:</p> <p>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 was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits weekly (while manager new in role) and completes a report to the general manager Care Homes. Hayman is part of the northern 1 Bupa region which includes nine facilities. The managers in the region teleconference fortnightly. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Hayman and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Hayman annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Hayman has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents (98.5% of their staff have completed Personal best to bronze or silver level and 51% of these are at Gold level). The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. 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 were rolled out in end 2011. 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 organisation has a Clinical Governance group. The committee is to continue meeting two monthly. They review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet 2 monthly. Hayman management team provided improvements made since their previous audit and examples of quality initiatives that align with Bupa goals. Improvements made have come through in their Residents Satisfaction survey with overall satisfaction in 2011 at 91% and 2012 at 90%. They also met their quality goal for 2012 of obtaining 75% and above for return rate. They had a return rate 2012 of 76%. They have met a number of quality goals for 2012 and 2013 to date including; a) they have reached 76% of staff enrolled, completing or completed Career force levels 2,3 and 4 and continue to encourage all their staff to complete this training. This was a goal for 2012 and has continued in 2013. b) Development of the Kaiarahi Uaara role is well in place with an increase in Maori residents to 25%. The role has been successful with the Kaiarahi Uaara (liaising between Maori residents and their families and providing information and reassurance around coming into care. c) The rate of falls has been reduced in the hospital with a review of staffing at different times, input from their care team and individualised plans, d) The residents have their own voted representative who speaks on their behalf and ensure resident's needs are met, e) They have developed a Hayman Dementia think tank group which involves clinical and activities staff as well as invited guests. This group has become a finalist in the Westpac Auckland South Business Awards 2013.</p>
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1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and COR competency questionnaires. Interviews with ten caregivers across morning and afternoon shifts (six hospital, two rest home, two dementia) showed an understanding of the key principles of the code of rights. Training provided Feb 13 (23 attended).

Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. Information is also given to next of kin or EPOA to read and discuss to or with the resident in private. On entry to the service, the manager discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available around the facility. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Interviews with nine residents (four hospital, five rest home) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Interviews with five relatives (three hospital, two dementia) confirmed they are informed of the code of rights and this is also discussed at resident/relative meetings.

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

Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The confidentiality and resident privacy policy states the manager is the privacy officer. Privacy and communication training was July 13 (10 staff attended). A quality alert from head office regarding a learning from an incident from another Bupa facility in regards to privacy April 13 resulted in a training session with qualified staff.

During the tour of the facility respect for privacy and personal space was demonstrated. Resident files are held in the rest home, dementia and hospital locked nurses' office/station. Interview with caregivers (six hospital, two rest home, two dementia) could explain ways resident privacy is maintained. Interviews with nine residents confirmed that privacy is ensured. The Sept 2012 resident satisfaction survey identified that 97% residents stated privacy was either excellent or good.

Resident information includes Bupa vision and values. Discussions with residents and relatives were positive about the service in respect of considering and being responsive to meeting values and beliefs. There is a large multi-cultured staff and residents at Hayman. There is a staff member in a role as Kaiarahi Uaara - leading the bi-cultural partnership within the facility and community.

D4.1a Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery. An initial care planning meeting six weeks after admission is carried out, whereby the resident/family are invited to be involved - cultural/religious would be again considered at this time.

Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, meal times and meal alternatives, specific culture alternatives) and that staff are obliging around choice. Care plans reviewed identified specific individual likes and dislikes. Caregivers from each of the three areas could describe examples of giving residents choice including, what time they would like to get up and go to bed, if they would like a shower or not, what they would like to wear and choices about food and activities. There is a question around 'choice' in the Sept 2012 resident satisfaction survey, 87% of residents stated excellent or good. Two residents (YPD) interviewed stated they were supported to access community and encouraged to maintain independence.

A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training was last delivered in April 13 (24 staff attended). D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Person centred care/individuality and independence training is provided to staff annually (last March 12).

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

E4.1a: Two families interviewed from the dementia unit stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**Audit Evidence****Attainment: FA****Risk level for PA/UA:****Finding Statement**

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L **How is achievement of this standard met or not met?****Attainment: FA**

A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa's facilities. The CDHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Hayman has an attachment to the policy that relates specifically to their area. Local Iwi and contact details of tangata whenua are identified. Special events and occasions are celebrated at Hayman and this could be described by staff. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all

residents as part of their admission process. Four of the nine files reviewed were residents that identified as Maori. All four included cultural consideration/needs and involvement of whanau. Two Maori residents interviewed (hosp/rest home) confirmed support and consideration by staff. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member's stay/care

The service identified that with the increase in Maori residents to 25%, the development of the Kaiarahi Uaara role was very important. The management team and Kaiarahi Uaara interviewed stated the role has been successful with the Kaiarahi Uaara liaising between Maori residents and their families and providing information and reassurance around coming into care. Part of this has included filming for a dvd to answer questions Maori may have regarding care homes. A Kawanta has also been developed between Hayman Care Home and Manurewa Marae.

Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: CI

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with five relatives (three hospital, two dementia) all identified that values and beliefs were considered. Discussion with seven rest home, five hospital residents all stated that staff took into account their culture and values.

D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment, planning process and interviews with residents confirmed that cultural values and beliefs were considered and discussed during review of the care plan. D4.1c Care plans reviewed included the residents social, spiritual, cultural and recreational needs.

The service is commended for their innovative way of ensuring the cultural diversity of residents and staff are met and acknowledged

Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Audit Evidence

Attainment: CI

Risk level for PA/UA:

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

Family/whanau involvement is actively encouraged through all stages of service delivery.

Links are established with disability and other community representative groups as directed/requested by the resident/whanau.

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan.

Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family/whanau are invited to attend..

The service actively recognized that they are a very ethnically diverse facility, they have increased quality of life through providing a suitable diet for their purely vegetarian residents, pacific island residents, Indian, Maori, Muslim, and Hindu residents. The kitchen uses the bupa menu but has created a variety of supplementary meals which have been very well received by their resident's, this is on-going.

Finding Statement

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member's stay/care. The service identified that with the increase in Maori residents to 25%, the development of a Kaiarahi Uaara role was very important. The management team and Kaiarahi Uaara interviewed stated the role has been successful with the Kaiarahi Uaara liaising between Maori residents and their families and providing information and reassurance around coming into care. Part of this has included filming for a dvd to answer questions Maori may have regarding care homes. A Kawanta has also been developed between Hayman Care Home and Manurewa Marae. The Food for Thought Committee which includes qualified dietitian. The service is multi-cultural and staff, resident and relatives interviewed informing a range of alternatives are offered to meet particular cultural needs - e.g. halal options, Dahl and boil-ups. The varied menu reflecting the diversity of the cultures at Hayman Home and hospital. Residents are offered rice daily as an alternative accompaniment if they wish. The service has also developed a Hayman Dementia think tank group which involves clinical and activities staff as well as invited guests. This group has become a finalist in the Westpac Auckland South Business Awards 2013. Meeting minutes include discussion of specific residents with behaviours that challenge and consider cultural needs when managing. Interviews with 10 caregivers identified that a number of residents speak different language and there are a number of staff that can speak the many languages at Hayman. Family interviewed confirmed that the service goes out of their way to ensure cultural, values and beliefs are identified and the monthly resident/family forum is also a great opportunity to share specific ways they could meet specific needs.

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. Enrolled nurses work under the direction and supervision of registered nurses. There are six enrolled nurses at Hayman, one

enrolled nurse is the unit coordinator in the rest home area and they are all overseen by the clinical manager. The EN's have transitioned to the Nursing Councils new scope of EN practice.

There is policy to guide staff practice: Gift, Gratitude's and Benefits, Delegations of Authority. Qualified nurses meeting (monthly) includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. The code of conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. Interviews with three registered nurses and two enrolled nurses (including one unit coordinator) described professional boundaries.

Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Hayman is currently benchmarked in three areas (hospital, rest home, dementia). A quality improvement programme is implemented that includes performance monitoring. Graphs and data is provided to Hayman staff on the noticeboard and corrective actions completed when trends are evident or areas are above the benchmark, i.e.: falls were above the benchmark in Feb/Mar 2013 in the dementia and hosp. A quality action form has been established. 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 was commenced Jan 10. Bupa has robust quality and risk management systems and these are implemented at Hayman supported by a number of meetings held on a regular basis

ARC A2.2 Services are provided at Hayman that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. ARC D1.3 all approved service standards are adhered to.

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

There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.

Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Hayman. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), Hayman is part of this. There is a dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting.

ARC D17.7c There are implemented competencies for careworkers, enrolled nurses and registered nurses. Standardised annual education programme, core competency assessments and orientation programmes have been implemented at Hayman. Competencies are completed for key nursing skills at Hayman including (but not limited to); a) moving & handling, b) wound care, c) sub cut fluids, d) assessment tools and e) medication. RNs have access to external training.

A residents/relatives association was also 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 of which also involves from the exec team the CEO, GM Quality and Risk and Consultant Geriatrician currently meets every three months.

Discussions with nine residents and four relatives were positive about the care they receive.

Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.

The three registered nurses and three unit coordinators interviewed stated that they record contact with family/whanau on the family/whanau contact record.

Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for August 13 identified that in 23 of 20 hospital incident forms, two of two rest home and eight of eight dementia incident forms identified that family were notified (the seven in the hospital involved one resident that has no identified contact or family). As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was last completed in March 2013 at Hayman with a result of 98.5%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b All five relatives (three hospital, two dementia) interviewed stated that they are always informed when their family members health status changes. One family member stated that at times she was informed later in the day instead of at the time of incident. This was brought up with management and has been addressed.

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.

In September 2009 Bupa NZ welcomed the appointment of a communications manager to the group. This person's role is to keep people informed and engaged about Bupa NZ's strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.

Interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and Government Agencies is available. In addition there are a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also 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.

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

Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.1.10 Informed Consent

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
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The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are procedure information sheets available including (but not limited to); a) minor skin surgery, b) catheterisation, and c) sub cut fluids.

Required consent forms and advance directive forms were evident on nine resident files reviewed.

Discussions with ten caregivers (six from the hospital, two from the rest home and two from the dementia unit) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with three registered nurses and three unit coordinators identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

There is an advance directive policy. The Bupa care services resuscitation of residents policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The "decisions relating to cardiopulmonary resuscitation" pamphlet and advance directive form will be given to the resident and completed. The medical resuscitation treatment plan and resuscitation advance directive will be completed as soon as possible after admission (no more than six weeks).

Completed resuscitation treatment plan forms were evident on all nine resident files reviewed. The service is working through ensuing all files evidence written discussion with family.

D13.1 There were nine admission agreements sighted and all had been signed.

D3.1.d Discussion with six family (two from the dementia unit and four from the hospital) identified that the service actively involves them in decisions that affect their relatives lives.

Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with three registered nurses described how residents are informed about advocacy and support. There is a list of advocates on the resident noticeboard and one resident acts as the resident representative and speaks for other residents at the resident/family forum.

Interviews with nine residents (four hospital, five rest home) confirmed that they are aware of their right to access advocacy.

D4.1d; discussion with five relatives (three hospital, two dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e; two rest home, three hospital and four dementia resident files reviewed included information on residents family/whanau and chosen social networks.

Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Visitors were observed coming and going during the audit. There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. D3.1.e: Interviews with nine residents (four hospital, five rest home [including two YPD]) confirmed that the activity staff help them assess the community such as go shopping. The following 'Personal Best' examples were provided in regards to accessing the community, staff escorting residents shopping, taking residents out ANZAC celebrations and one on one walks.	

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		

Timeframe:

Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

Complaints received each month are reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed.

Verbal complaints are also included and actions and response are documented. Discussion with nine residents (four hospital, five rest home) and five relatives (three hospital, two dementia) confirmed they were provided with information on complaints and complaints forms. 2013 YTD complaints were reviewed and included two written complaints and one verbal complaints. All were well documented including investigation, follow up letter and resolution. The Dec 2012 complaint that had gone to the DHB was reviewed and included follow up and letter from DHB stated it was unsubstantiated.

Two relatives interviewed stated they had made complaints via emails and that these were well managed and addressed. However, it was noted that these were not all included in the complaints register or consequent follow up documentation identified.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

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 and nature (theme) of complaints received each month is reported monthly to Quality and Risk via the facility benchmarking spreadsheet'.

The complaints procedure is provided to resident/relatives at entry and also prominent around the facility.

Verbal complaints are also included and actions and response are documented. Discussion with nine residents (four hospital, five rest home) and five relatives (three hospital, two dementia) confirmed they were provided with information on complaints and complaints forms. 2013 YTD complaints were reviewed and included two written complaints and one verbal complaints. All were well documented including investigation, follow up letter and resolution. The Dec 2012 complaint that had gone to the DHB was reviewed and included follow up and letter from DHB stated it was unsubstantiated.

Finding Statement

Two relatives interviewed stated they had made complaints via emails and that these were well managed and addressed. However, it was noted that these were not all included as part of the complaints register and consequent follow up documentation identified.

Corrective Action Required:

Ensure concerns/complaints brought up by family via email or verbally are included as part of the complaints management system

Timeframe:

6 months

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?**Attainment: CI**

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. Hayman has set specific quality goals for 2013 including (but not limited to); a) reduction from 2012 of pressure area wounds by 20%, b) reduction in falls in hospital care by 20%, c) 75% of caregivers will hold or be enrolled for level 2- core competencies qualification and 100% of rostered dementia staff will hold level 4, d) better inform residents and feel they are truly partners in care, food will reflect and respect the ethnicities onsite and increase food satisfaction to 90%, e) the development of areas that bring comfort to residents. Area that are both internal and external by providing a range of diverse environments that are relevant to residents, f) the six core Maori values as discussed in the Bupa Maori Health plan are evidenced throughout the care home showing genuine partnership, protection and participation with Maori..

Bupa Hayman provides hospital - medical/geriatric, rest home, dementia care and residential disability - intellectual/physical for up to 87 residents. There were 16 of 16 rest home residents, 29 of 32 hospital residents and 34 of 34 residents in the dementia units (one male only unit of 15 residents and one female unit of 19 residents). There are 11 residents under YPD contracts (seven residents are in care due to physical needs and four residents are in care due to intellectual needs.).

The organisation has commenced a Clinical Governance group. The committee is to continue meeting two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet 2 monthly.

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 was commenced Jan 10.

The Facility Manager (RN) has been in the role since May. She was previously the clinical manager for over five years. She also has a Post Cert in Gerontology. She is supported by a Clinical Manager (RN). There are job descriptions for both positions that include responsibilities and accountabilities. The managers are supported by a unit coordinators in the three areas.

Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

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

Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**Audit Evidence****Attainment: CI****Risk level for PA/UA:**

Bupa Hayman provides hospital - medical/geriatric, rest home, dementia care and residential disability - intellectual/physical for up to 87 residents. There were 16 of 16 rest home residents, 29 of 32 hospital residents and 34 of 34 residents in the dementia units (one male only unit of 15 residents and one female unit of 19 residents). There are 11 residents under YPD contracts (seven residents are in care due to physical needs and four residents are in care due to intellectual needs.). 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.

Hayman has set specific quality goals for 2013 including (but not limited to); a) reduction from 2012 of pressure area wounds by 20%, b) reduction in falls in hospital care by 20%, c) 75% of caregivers will hold or be enrolled for level 2- core competencies qualification and 100% of rostered dementia staff will hold level 4, d) better inform residents and feel they are truly partners in care, food will reflect and respect the ethnicities onsite and increase food satisfaction to 90%, e) the development of areas that bring comfort to residents. Areas that are both internal and external by providing a range of diverse environments that are relevant to residents, f) the six core Maori values as discussed in the Bupa Maori Health plan are evidenced throughout the care home showing genuine partnership, protection and participation with Maori.

There is an overall Bupa business plan and risk management plan.

Hayman has a very diverse cultural make-up with many different ethnicities present. A large percentage of staff are Maori and Hayman have taken this to heart by embracing six core Maori values. Unique to Hayman also is the role of the Kaiarahi Uaara, which means to 'lead out', This is a partnership role, and involves making connections with families to ensure residents receive the highest quality care.

Finding Statement

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 was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits weekly (while manager new in role) and completes a report to the general manager Care Homes. Hayman is part of the northern 1 Bupa region which includes nine facilities. The managers in the region teleconference fortnightly. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Hayman and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Hayman annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Hayman has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents (98.5% of their staff have completed Personal best to bronze or silver level and 51% of these are at Gold level). The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. 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 were rolled out in end 2011. 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 organisation has a Clinical Governance group. The committee is to continue meeting two monthly. They review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet 2 monthly. Hayman management team provided improvements made since their previous audit and examples of quality initiatives that align with Bupa goals. Improvements made have come through in their Residents Satisfaction survey with overall satisfaction in 2011 at 91% and 2012 at 90%. They also met their quality goal for 2012 of obtaining 75% and above for return rate. They had a return rate 2012 of 76%. They have met a number of quality goals for 2012 and 2013 to date including; a) they have reached 76% of staff enrolled, completing or completed Career force levels 2,3 and 4 and continue to encourage all their staff to complete this training. This was a goal for 2012 and has continued in 2013. b) Development of the Kaiarahi Uaara role is well in place with an increase in Maori residents to 25%. The role has been successful with the Kaiarahi Uaara (liaising between Maori residents and their families and providing information and reassurance around coming into care. c) The rate of falls has been reduced in the hospital with a review of staffing at different times, input from their care team and individualised plans, d) The residents have their own voted representative who speaks on their behalf and ensure resident's needs are met, e) They have developed a Hayman Dementia think tank group which involves clinical and activities staff as well as invited guests. This group has become a finalist in the Westpac Auckland South Business Awards 2013.

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

During a temporary absence, the clinical manager covers the managers role. The service is supported by the Bupa Operations Manager. There is a unit coordinator (RN) across the hospital, rest home and dementia units.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to people who use the service including residents that require hospital (medical), rest home, dementia and those younger residents under YPD contracts. There are 11 residents under YPD contracts (seven residents are in care due to physical needs and four residents are in care due to intellectual needs.). There is a house GP that visits two mornings a week. A physiotherapist undertakes twice weekly visits and completes mobility assessments for each resident and reviews (transfer plans in clinical file and in bedrooms.) Assesses for treatment and rehabilitation and then documents and discusses plans with Unit Co-ordinators. An occupational therapist provides services as required. She is an access able assessor and is used to assess residents for sitting, wheelchairs and specific equipment that may be needed to aid daily living. A dietitian provides six weekly visit to assess residents

requiring dietary input and reviews and monitors residents already assessed as needing dietary input. Attends food for thought meetings and advises qualified staff and kitchen.

The service consults with the Bupa dementia leadership group, gerontology nurse specialists (which meet with the RNs for peer review two monthly), physiotherapist, dietitian, and mental health for older people.

Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Hayman has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request

forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team.

Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule.

Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and 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 two monthly quality committee. 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 manager that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. There is a two monthly IC committee meeting. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. Health and safety committee meets two monthly is also an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation.

Monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Hayman via graphs and benchmarking reports.

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the Operations Managers region is also provided for the Ops Mgr which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Ops Mgrs mthly summaries).

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Hayman and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.

D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2013 with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury (these have continued from 2012).

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.

Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;
- (e) Restraint minimisation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where 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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The completed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Bupa have now also introduced a dedicated email address to send CAT ones to. Manned by more than one specific person – that was described as an improvement within Bupa Q+R team. A monthly Cat One summary is also sent out to care homes.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

Incident forms reviewed for August 13 identified that in 23 of 23 hospital, two of two rest home and eight of eight dementia incident forms demonstrated clinical follow up by a registered nurse/unit coordinator and monitoring (such as neuro obs) having been undertaken when indicated.

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

Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Ten files reviewed files (two registered nurses, one unit coordinator, three caregivers, clinical manager, cook, activity therapist, enrolled nurse) all had up to date performance appraisals. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of

time (e.g. caregivers two weeks, RN four weeks), during this period they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (10 caregivers, three registered nurse, three unit coordinators) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the staff educator confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (These align with Bupa policy and procedures).

There is an annual education schedule that is being implemented. In addition opportunistic education is provided by way of tool box talks. There is an RN training day provided through Bupa that covers clinical aspects of care - eg. Wound management . External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the two monthly quality meetings. Toolbox talks held on a regular basis and staff been encouraged to participate.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a Nursing Council approved PDRP. The Nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At Hayman, one RN and one EN are in the process of completing their portfolio on the Bupa Nursing Council approved PDRP.

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

E4.5f There are 17 full time and part time caregivers that work in the dementia units. All 17 have completed the required dementia standards.

Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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

There is a Facility Manager (RN) Mon - Fri and a Clinical Manager (RN) Mon - Fri.

There is good registered nurse cover. There are two unit coordinators (RNs). One in the hospital and one across the two dementia units. There is also an EN unit coordinator in the rest home and a RN in the rest home three afternoons a week. In the rest home the clinical manager also provides oversight. There are two RNs on at night plus two caregivers across the service at least four nights a week, the remainder nights there is one RN with three caregivers. There are two- three RNs rostered AM and PM shift plus unit coordinators across the service.

With the verification of the five extra dementia beds, the roster includes an increase in caregiver hours in the unit.

Interviews with 11 relatives and 12 residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that they have input into the roster and management were supportive around change when times are busier.

There is a documented staffing rationale at roster in place.

Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: PA Low
<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time.</p> <p>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure cabinet or secure storage for unused files.</p>	

<p>Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. There is also an allied health services assessment form with care requirements.</p> <p>D7.1 Policies contain service name. Incident forms reviewed for August were thoroughly completed, however a number of different staff were noted to have documented on the incident form particularly in relation to clinical assessment and follow up post-incident. Not all entries were signed and dated and therefore difficult to determine who the writer was and when it was documented.</p>
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Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Overall care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing.

Finding Statement

Incident forms reviewed for August were thoroughly completed, however a number of different staff were noted to have documented on the incident form particularly in relation to clinical assessment and follow up post-incident. Not all entries were signed and dated and therefore difficult to determine who the writer was and when it was documented.

Corrective Action Required:

Ensure all entries on incident forms are signed and dated.

Timeframe:

6 months

Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service.

Information gathered at admission is retained in resident's records. Nine residents and six family members interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Four resident files in the dementia unit were reviewed and all includes a needs assessment as requiring specialist dementia care.

Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.	

Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.3.3 Service Provision Requirements

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; D16.3i; 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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?**Attainment: FA**

There is an admission – role of caregiver policy, an admission – role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.

A registered nurse undertakes the assessments on admission in each unit, with the initial support plan completed within 24 hours of admission. Within three weeks the care plan is developed in eight of nine files sampled (one resident is a new admission).

In nine of nine files sampled (four from the two dementia units, three from the hospital and two from the rest home [including three for residents under 65 years old]) the initial admission assessment, care plan summary and long term care plan (where the resident has been at the service more than three weeks) were completed and signed off by a registered nurse. Medical assessments are completed on admission by the GP in nine of nine files sampled and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person.

Activity assessments and the activities sections care plans have been completed by a diversional therapist.

Nine residents interviewed (four hospital and five rest home [including two under 65 years old]) stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed and up to date in nine resident files sampled.

D16.2, 3, 4: The nine of nine files sampled (four from the dementia unit, three from the hospital and two from the rest home), identified that in all nine files an assessment was completed within 24 hours and eight of nine. Files identify that the long term care plan was completed within three weeks (one resident is a new admission). There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. Eight of nine care plans evidenced evaluations completed at least six monthly (one resident is a new admission).

D16.5e: Nine resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment.

The care plan summary policy (371) states "the care plan summary is completed by the registered nurse within one week of admission. It is a summarised account of the cares a resident needs and will be used by caregivers to ensure care delivery is in line with the care plan. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change)". Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Nine files identified integration of allied health and a team approach is evident in the nine files. The GP interviewed spoke positively about the service and describes very effective communication processes.

All nine files have at least an initial physiotherapy assessment with on-going assessments as necessary.

Tracer Methodology hospital:

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

Tracer methodology rest home:

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

Tracer methodology dementia unit:

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

Tracer methodology under 65 years:

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

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.3.4 Assessment

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

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>Hayman have implemented the revised Bupa assessment booklets and templates for all residents. The assessment booklet provides very in-depth assessment tools including; falls, Braden, skin, mini nutritional, continence, pain, dependency and activities. The falls assessment section also includes additional risk factors, for example; vision, mobility, behaviours, environment and continence.</p> <p>Risk assessment tools and monitoring forms are reviewed at least six monthly and are used to effectively assess level of risk and required support for residents including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, MNA, incontinence assessment, behaviour assessment, pain assessment, skin assessment, dependency rating and wound assessment.</p> <p>The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information.</p> <p>Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse.</p> <p>Nine of nine files sampled (four from the dementia unit, three from the hospital and two from the rest home including three for residents under 65 years old) contain assessments including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, skin assessment, MNA, incontinence assessment, behaviour assessment, and wound assessment (where appropriate).</p> <p>Assessments and support plans are comprehensive and include input from allied health. The assessment booklet includes input from team members.</p>	

Notes by GP and allied health professionals are evident in residents files, significant events, communication with families and notes as required by registered nurses. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met.

ARC E4.2: Four resident files reviewed in the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed.

Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

A sample of six files was reviewed.

Service delivery plans (care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health.

Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Assessments completed on admission are comprehensive. The long-term care plan is completed within three weeks with GP involvement within 48 hours.

Plans are well described and are reflected in the progress notes. Six of nine residents' care plans reviewed on the day of the audit (three hospital, four dementia, two rest home including three for residents under 65 years old) provide evidence of individualised support and intervention required. One care plan did not include seizure management, one did not include pain management and one did not include falls management. This is an area requiring improvement.

Nine residents interviewed (four hospital and five rest home including two under 65 years old) and six family (two from the dementia unit and four from the hospital) confirm care delivery and support by staff is consistent with their expectations. All needs identified in the assessment process were included in the care plans.

There is a long term care plan that includes; a) hygiene, b) medical, c) skin and pressure area care, d) bladder and bowels, e) mobility, f) food and fluids, g) rest and sleep, h) communication, i) emotional well-being, j) spirituality, k) religion and culture, and l) activities.

Care plans demonstrate service integration. The assessment booklet includes input from team members including the activities coordinator.

Notes by GP and allied health professionals, significant events, communication with families are included in the sample group of residents files.

E4.3 Four resident files from the dementia unit reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

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

D16.3f: Nine resident files reviewed identified that family were involved.

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Service delivery plans (care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health.

Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Assessments completed on admission are comprehensive. The long-term care plan is completed within three weeks with GP involvement within 48 hours. Plans are well described and are reflected in the progress notes. Six of nine residents' care plans reviewed on the day of the audit (three hospital , four dementia, two rest home) provide evidence of individualised support and intervention required.

Finding Statement

Three of nine resident files do not include interventions for all identified needs. Examples include seizure management, pain management and falls management.

Corrective Action Required:

Ensure all identified needs have corresponding interventions in the care plans.

Timeframe:

3 months

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

Residents' care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by a registered nurse in all three areas. Care delivery is recorded and evaluated by registered nurses on each shift in the hospital and at least daily in the rest home and dementia unit (evidenced in all nine residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The 10 caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Nine residents interviewed (four hospital and five rest home including two under 65 years old) and six family (two from the dementia unit and four from the hospital) were complimentary of care received at the facility.

The care plans reviewed were all completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with 10 caregivers, six families interviewed, three registered nurses, three unit managers, the facility manager and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status.

One file sampled is for a resident requiring two hourly turns. The turning charts evidences that the turns have not occurred two hourly. The sample was increased to include a further two hourly turning charts and both indicate that the residents have not been turned two hourly. This is an area requiring improvement.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 19 residents including two pressure areas. Nine of these wounds have not been reviewed in the stated timeframe and this is an area requiring improvement.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. The facility has registered nurse cover 24/7 and has an 'in service' education programme.

A record of all health practitioners practicing certificates are kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse.

Care plans are goal oriented and reviewed six monthly. During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

The service has a bi-monthly dementia think tank meeting which is attended by the facility manager, the clinical manager, the unit coordinators and the mental health service for older people. At this meeting all residents who present any behaviours that challenge are discussed and brainstorming occurs to attempt to identify any better ways to meet resident's needs.

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.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Residents' care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by a registered nurse in all three areas. Care delivery is recorded and evaluated by registered nurses on each shift in the hospital and at least daily in the rest home and dementia unit (evidenced in all nine residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The 10 caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Nine residents interviewed (four hospital and five rest home including two under 65 years old) and six family (two from the dementia unit and four from the hospital) were complimentary of care received at the facility.

The care plans reviewed were all completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with 10 caregivers, six families interviewed, three registered nurses, three unit managers, the facility manager and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status.

Finding Statement

(i) One file sampled is for a resident requiring two hourly turns. The turning charts evidences that the turns have not occurred two hourly. The sample was increased to include a further two hourly turning charts and both indicate that the residents have not been turned two hourly. (ii) Nine of 19 wounds have not been reviewed in the stated timeframe.

Corrective Action Required:

(i) Ensure two hourly turns are completed as required and these are documented. (ii) Ensure all wounds are reviewed within stated timeframes.

Timeframe:

3 months

STANDARD 1.3.7 Planned Activities

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is an activities coordinator and an activities assistant. The activities coordinator provides activities in the rest home and hospital and the activities assistant (Who is an occupational therapist) provides activities in the dementia unit. On the day of audit residents in all areas were observed being actively involved with a variety of activities. The programme is developed monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review/evaluated.

The programme includes networking within the community with social clubs, schools etc. On or soon after admission, a social history is taken and information from this is fed into the Careplan plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept individual residents activities. There are recreational progress notes in the resident's file that the activity officers completes for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in the rest home, hospital and dementia units, participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.

Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit which are conducted by care staff out of normal hours. The dementia specific care plan for all residents with dementia includes activities for the resident over the 24 hour period.

There are 11 residents under 65 years old at the service. All are invited to be involved in the weekly music therapy group which is aimed specifically at younger residents. Also residents are encouraged to access the community and most have regular visits to their homes. All are also supported to engage in previous interests. Examples include getting wrestling DVD's out, playing the guitar for the group and assisting with the care of the animals. Several male residents under 65 years are also involved in minor maintenance and helping out in the garden. The residents interviewed under 65 years report having plenty to do that is meaningful to them.

Bupa undertakes a programme called Personal Best. This programme supports staff to involve themselves beyond their role to allow them to experience their 'Personal Best'. It is designed to actively link staff to residents. By May 2012 85 % of staff had achieved their personal best to bronze level (more recent figures were not available) with many having reached gold awards. Many of these awards have centred around taking residents out into the community or bringing the community into the facility in some way. Hayman has hosted choirs and Sunday school classes and residents have received quilts, special days and lovely garden spots to enhance their life at Hayman.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least a one- three monthly review by the medical practitioner. Care plans are evaluated by the registered nurses six monthly or when changes to care occur as sighted in eight of nine care plans sampled (one dementia resident is new to the service). There is at least a monthly review by the medical practitioner for hospital residents and one to three monthly review for rest home and dementia residents.

There are short term care plans to focus on acute and short-term issues. Changes to the long term care plan are made as required and at the six monthly review if required. From the sample group of resident's notes the short term care plans are well used and comprehensive. Examples of STCPs in use included; infections, wounds, challenging behaviours, and unexplained weight loss.

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

ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Of the sample group of notes all of the residents/patients had signed the informed consent and had copies of the Code of Rights. Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, mental health services and hospital specialists.

D16.4c; The service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care.

D 20.1 Discussions with registered nurses identified that the service has access to speech language therapists, physiotherapist, occupational therapists, NASC, hospital specialists and dietitians.

Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident's file. This was sighted in three resident files (one from the rest home and two from the hospital including three for residents under 65 years old) where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the three wings. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications.

The service uses four weekly robotic packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.

There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Registered nurses are peer reviewed annually and caregivers are selected by the clinical manager and trained in medication administration and competency checked annually. Only those staff deemed competent administer medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off.

All 'medication competent' staff are responsible for medication administration in all areas. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers

Medication management was held in July 2013.

Medication – self administration policy (098) states self –administration of medication will be documented in the residents care plan.

- The medications will be charted in the usual way and the nursing staff will enter S/A (self-administered).

- The registered nurse will follow-up and be satisfied that the resident's self-administering medications are being taken every 24 hours. This is to be noted on the medication chart.

- The resident will be reviewed every three months as to the safety of being able to continue

There is currently one resident self-administering at Hayman. This person has a current competency assessment.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart for three of 18 medication charts sampled. This is an area requiring improvement. The controlled drug register is well kept and aligns with legislative

requirements. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies, e) duplicate name.

The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the residents' general practitioner at least three monthly. Charts are easy to read and current. Medication audits are completed six monthly.

There is a quality goal at an organisational level to reduce the use of antipsychotics. Advised this is progressing with currently 28% of the facilities total residents being on a medication. This includes PRN medication and they are monitoring their residents to enable them to remove the medication completely. At Hayman, 37% of residents in the dementia unit are on antipsychotics. Every client is on antipsychotic medication management plan. This plan includes a review of the use, has the outcome been met, describe any current behaviour or psychological symptoms or drug side effects, a rationale for dose change and that the dose should be reduced by 25 % at each review and if not why not. Antipsychotic use is also discussed at the bi monthly dementia think tank meetings.

D16.5.e.i.2; Fourteen of 16 medication charts reviewed identified that the GP had reviewed the residents medication chart three monthly (this is an area requiring improvement) and the medication chart was signed.

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the three wings. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications.

The service uses four weekly robotic packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.

There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart for three of 18 medication charts sampled. The controlled drug register is well kept and aligns with legislative requirements.

Finding Statement

(i) Two of 18 medication charts sampled have not been reviewed in the past three months. (ii) Two of 18 medication administration signing sheets show that medication has been signed as administered that is not prescribed. (iii) Fifteen of 18 medication signing sheets have medication that is charted as regular but has not been signed as administered regularly.

Corrective Action Required:

(i) Ensure all medication charts are reviewed at least three monthly. (ii) and (iii) Ensure all medication is administered as prescribed.

Timeframe:

3 months

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

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.

The service employs nine kitchen staff including four cooks. The main kitchen supplies meals for the hospital/rest home and the dementia unit.

All of the kitchen team at Hayman have completed food safety certs.

The service has a large workable kitchen that contains a walk-in pantry, freezer, Domestic fridge with snacks for dementia unit, walk in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after 6 weeks. There are a number audits completed include; a) kitchen audit, b) Environment kitchen, c) Catering service survey, and d) Food service audit.

The kitchen has recently developed large print menus with pictures of the main meal each day to make them more able to be understood by residents.

There is a nutrition - assessment and management policy (347) and a weight management policy (079).

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets and diabetics.

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.

Daily temperature checks of chiller, freezers, bain marie and dishwasher are maintained except one fridge in the hospital lounge which has consistently been recorded (incorrectly) at 77 degrees with no corrective action undertaken. This is an area requiring improvement.

All kitchen staff have completed food-handling certificates.

Bupa Care Homes introduced in 2010 a comprehensive food services programme that specifically targeted all areas of the food service as a quality improvement initiative throughout the business. This was in response to further improving on client satisfaction results with the service as identified through resident/relative satisfaction surveys. Achievements of the programme which continues in 2012 include the introduction of a Steering group, monthly teleconferences with the chefs/cooks employed in each home, development of Bupa's own Recipes and Library of these and the review and update of all

kitchen policies and procedures. Other activities included the development of "assisted eating posters" which a "Masterchef" DVD with Annabelle White, a dementia specific focus included emphasis on use of coloured crockery and suitable tasty finger foods and a streamline national food contract supply for meat, groceries and vegetables. The programme also developed food safety training powerpoints to augment the internal core education programme within care homes. A senior chef within the business provides support and mentorship to the cooks in each of the homes and following the pilot of a training programme for staff, Bupa kitchen staff complete unit standard 167 Food safety training . "Showing we care on a plate" was the title/catch phrase for the programme. This was described by the cook.

The service has a bi monthly 'Food for Thought' meeting which is attended by the facility manager, the clinical manager, the kitchen manager, the unit coordinators and the dietitian. At this meeting there is a full discussion around the food service, focussing on any residents with recent or on-going weight loss and what can be done to reduce or manage this weight loss.

The service also caters for many cultural and religious meals. On a daily basis they provide two halal and two kosher meals and caters for one vegetarian who is Indian and primarily eats curries. They also frequently provide boil ups, fish heads and mutton birds for Maori residents and salty beef, taro and other Pacific Island meals for those residents.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours

D19.2: Staff have been trained in safe food handling.

Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

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.

The service employs nine kitchen staff including four cooks. The main kitchen supplies meals for the hospital/rest home and the dementia unit.

All of the kitchen team at Hayman have completed food safety certs.

The service has a large workable kitchen that contains a walk-in pantry, freezer, Domestic fridge with snacks for dementia unit, walk in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after 6 weeks. There are a number audits completed include; a) kitchen audit, b) Environment kitchen, c) Catering service survey, and d) Food service audit.

Finding Statement

There is one fridge in the hospital lounge which has consistently been recorded (incorrectly) at 77 degrees with no corrective action undertaken.

Corrective Action Required:

Ensure all fridges are maintained at a safe temperature.

Timeframe:

6 months

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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Chemical/substance safety policy (048). There are policies on the following:- waste disposal policy. - medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled food, broken glass or crockery, tins, cartons, paper and plastics. Procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff and an education conducted in March 2013 around chemical safety.

All chemicals are clearly labelled with manufacturers labels. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols.

Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled.

Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

There is a maintenance person who works a total of 40 hours per week and on call. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 16 March 2014. Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

This audit has assessed five rooms currently being used as rest home level rooms as suitable to be used as part of the dementia unit. The extra five beds being assessed as suitable for an addition to the dementia unit do not yet have a keypad on the door to make the area secure. This is an area requiring improvement.

The external areas are well maintained and gardens are attractive. There is garden furniture and plenty of shade. There is wheelchair access to all areas. The garden is secure and there is shade.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors and lifting aids.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c: There is a safe and secure outside area that is easy to access.

Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

Finding Statement

The extra five beds being assessed as suitable for an addition to the dementia unit do not yet have a keypad on the door to make the area secure.

Corrective Action Required:

Ensure the new wing being added to the dementia unit has a secure door.

Timeframe:

Prior to use of the extension in the dementia unit.

Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The facility has four wings (one hospital, one rest home and two secure dementia units). There are showers and toilets throughout the facility. The five bed wing being assessed as suitable to be used as part of the Te Rangi Marie dementia wing has a separate toilet and shower. There are adequate visitor and staff toilet facilities available. Communal toilets and bathrooms have appropriate signage and shower curtains installed. Nine residents interviewed (four hospital and five rest home including two under 65 years old) report their privacy is maintained at all times.

Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The rooms are spacious it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Ten caregivers from across each area report that rooms have sufficient rooms to allow cares to take place. The five rooms being assessed as suitable for extending the dementia unit are suitable for rest home level residents.

Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Audit Evidence**Attainment:** FA**Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

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

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?**Attainment:** PA Low

There is a large lounge and large separate dining room for each of the rest home and hospital residents. There is a separate lounge in each dementia wing. The lounge and dining room in the Te Rangi Marie dementia unit, which is being assessed to include five extra beds is not of sufficient size to accommodate an extra five residents. There are plans in place to extend the lounge and dining room in the Te Rangi Marie area. This is an area requiring improvement. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and nine residents interviewed report they can move around the facility and staff assist them if required.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**Audit Evidence****Attainment:** PA**Risk level for PA/UA:** Low

There is a large lounge and large separate dining room for each of the rest home and hospital residents. There is a separate lounge in each dementia wing.

Finding Statement

The lounge and dining room in the Te Rangi Marie dementia unit, which is being assessed to include five extra beds is not of sufficient size to accommodate an extra five residents. There are plans in place to extend the lounge and dining room in the Te Rangi Marie area.

Corrective Action Required:

Ensure there is sufficient space in communal areas to accommodate all residents in Te Rangī Marie.

Timeframe:

Prior to use of the extension in the dementia unit.

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.

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed twice a year and last done July 2013 (98%). An environmental hygiene - cleaning audit was last completed in August 2013 (100%). Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room . All chemicals are labelled with manufacturer’s labels. There is sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.7 Essential, Emergency, And Security Systems

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety in February 2013. Fire evacuations are held six monthly. A fire evacuation was last held on 16 August 2013.

There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents' details. There is an approved evacuation plan dated 12 August 2006.

The facility is well prepared for civil emergencies and has emergency lighting and BBQ's. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits.

Hoists have battery back and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept.

There is a store cupboard of supplies necessary to manage a pandemic.

The call bell system is available in all areas and indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were overall answered in a timely manner.

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

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The facility has radiators and ceiling heating which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored.

Nine residents interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident's rooms.

Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Restraint policy (251) states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however we acknowledge that there may be occasions when a resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated

There is a Regional Restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service remains restraint and enabler-free.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The infection control committee includes a cross section of staff all areas of the service.

The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, Community Lab, the infection control and public health departments at the local DHB. There are monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff.

Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

A gastric outbreak Jan 13 which included 13 residents was well managed and retained in one of the dementia units, rest home and one of the hospital wing. Five staff were affected. The service completed an IC summary report, STCP, contact precautions and isolation procedures put in place, case log documented. In July 13 a special report was completed for ? scabies in the dementia unit. Residents and staff treated, families informed. Skin scraping was negative and no further episodes of rashes noted.

A monthly MRO report completed, July identifies 12 residents which includes precaution risk and current status. MRO status linked to care plans.

Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the facility manager, clinical manager (ICN), registered nurses and other staff. The clinical manager has recently taken over the role from the Facility Manager (FM) and the FM continues to provide a supporting role. The facility also has access to an infection control nurse, public health, community lab, GP's and expertise within the organisation.

Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 3.3 Policies and procedures

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.</p> <p>There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.</p> <p>Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.</p> <p>External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator, the infection control committee and expertise from the governing body.</p>	

Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator is booked to complete external infection control training next month. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, and Bug Control for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was held on March 13 (25 attended), scabies (May 13- 16 attended), safe food handling IC/MRO (June 13 - 15 attended), Norovirus (Aug 13- 10 attended) and food safety (Aug 13 - six attended). All training is mandated by Bupa and evaluated by staff who attend. Records of the evaluations were sighted.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza and gastro bugs.

Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 Surveillance

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, RN/EN and infection control meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Quality action forms have been completed for ' yellow linen bags on floor Aug 13 and prevention of UTIs Jan 13.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe: