

# Bupa Care Services NZ Limited - Cornwall Park Hospital

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Current Status: 29 October 2013

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

## General overview

Cornwall Park Hospital is part of Bupa Care Services NZ Limited. The service provides hospital (psychogeriatric) level care for up to 39 residents. On the day of audit there were 39 residents.

Cornwall Park is currently being managed by an interim manager (registered nurse), experienced in aged care management. She is also supported by a clinical manager and Bupa regional manager. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Staff turnover remains low.

Family members interviewed stated that they are involved in planning their family members care.

The previous shortfall identified at the previous audit around dementia training has been addressed. This surveillance audit identified improvements required around aspects of meeting minutes, the short term care plan template and medication documentation.

## Audit Summary as at 29 October 2013

Standards have been assessed and summarised below:

### Key

| Indicator | Description   | Definition   |
|-----------|---|--|
|           | Includes commendable elements above the required levels of performance  | All standards applicable to this service fully attained with some standards exceeded |
|           | No short falls  | Standards applicable to this service fully attained                                  |
|           | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk         |

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

### Consumer Rights as at 29 October 2013

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

### Organisational Management as at 29 October 2013

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

### Continuum of Service Delivery as at 29 October 2013

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

### Safe and Appropriate Environment as at 29 October 2013

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

### Restraint Minimisation and Safe Practice as at 29 October 2013

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

## Infection Prevention and Control as at 29 October 2013

|  |  |   |
|--|--|---|
| <p>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.</p> |  | <p>Standards applicable to this service fully attained.</p> |
|--|--|---|

# HealthCERT Aged Residential Care Audit Report (version 3.9)

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## Introduction

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

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

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

## Audit Report

|   |                                    |                                  |    |
|---|------------------------------------|----------------------------------|----|
| <b>Legal entity name:</b>   | Bupa Care NZ Ltd                   |                                  |    |
| <b>Certificate name:</b>  | Cornwall Park Hospital             |                                  |    |
| <b>Designated Auditing Agency:</b>  | Health & Disability Auditing NZ    |                                  |    |
| <b>Types of audit:</b>  | Surveillance                       |                                  |    |
| <b>Premises audited:</b>  | Cornwall Park Hospital             |                                  |    |
| <b>Services audited:</b>  | Psychogeriatric                    |                                  |    |
| <b>Dates of audit:</b>  | <b>Start date:</b> 29 October 2013 | <b>End date:</b> 29 October 2013 |    |
| <b>Proposed changes to current services (if any):</b>   |                                    |                                  |    |
|   |                                    |                                  |    |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> |                                    |                                  | 39 |

## Audit Team

|                          |        |                            |   |                             |   |
|--------------------------|--------|----------------------------|---|-----------------------------|---|
| <b>Lead Auditor</b>      | XXXXXX | <b>Hours on site</b>       | 7 | <b>Hours off site</b>       | 3 |
| <b>Other Auditors</b>    | XXXXXX | <b>Total hours on site</b> | 7 | <b>Total hours off site</b> | 3 |
| <b>Technical Experts</b> |        | <b>Total hours on site</b> |   | <b>Total hours off site</b> |   |
| <b>Consumer Auditors</b> |        | <b>Total hours on site</b> |   | <b>Total hours off site</b> |   |
| <b>Peer Reviewer</b>     | XXXXXX |                            |   | <b>Hours</b>                | 1 |

## Sample Totals

|  |    |                                   |    |                                      |    |
|--|----|-----------------------------------|----|--------------------------------------|----|
| Total audit hours on site                                      | 14 | Total audit hours off site        | 7  | Total audit hours                    | 21 |
| Number of residents interviewed                                |    | Number of staff interviewed       | 7  | Number of managers interviewed       | 3  |
| Number of residents' records reviewed                          | 6  | Number of staff records reviewed  | 7  | Total number of managers (headcount) | 3  |
| Number of medication records reviewed                          | 12 | Total number of staff (headcount) | 35 | Number of relatives interviewed      | 3  |
| Number of residents' records reviewed using tracer methodology | 1  |                                   |    | Number of GPs interviewed            | 1  |

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

|    |  |     |
|----|--|-----|
| a) | I am a delegated authority of the DAA  | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise          | Yes |
| c) | the DAA has developed the audit summary in this audit report in consultation with the provider                   | Yes |
| d) | this audit report has been approved by the lead auditor named above  | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook          | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | the DAA has provided all the information that is relevant to the audit   | Yes |
| h) | the DAA Auditing Agency has finished editing the document.   | Yes |

Dated Thursday, 21 November 2013

## Executive Summary of Audit

### General Overview

Cornwall Park is part of the Bupa group. The service provides hospital (psychogeriatric) level care for up to 39 residents. On the day of audit there were 39 residents.

Cornwall Park is currently being managed by an interim manager (registered nurse), experienced in aged care management. She is also supported by a clinical manager and Bupa regional manager. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Staff turnover remains low.

Family members interviewed stated that they are involved in planning their family members care.

The previous shortfall identified at the previous audit around dementia training has been addressed. This surveillance audit identified improvements required around aspects of meeting minutes, short term care plan template and medication documentation.

### Outcome 1.1: Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter's policy is in place. Family members and staff, from a range of cultures, are the most common source of interpreter services within the facility. External assistance is available if necessary.

The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed.

### Outcome 1.2: Organisational Management

Cornwall Park has an established quality and risk management system that supports the provision of clinical care and support. 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, and psychogeriatric/mental health services. Cornwall Park is benchmarked in one of these (psychogeriatric). 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. There is an improvement required around ensuring meeting minutes reflect follow through of actions required.

There are comprehensive 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 the requirements. All caregivers except two new staff have completed the required dementia standards and this is an improvement on previous audit.

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

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

Assessments, care plans and evaluations are completed by the registered nurses. Relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents including managing behaviours. Service delivery plans demonstrate service integration and are individualised. Short term care plans are in use for changes in health status. There is an improvement required around short term care plans. Care plans are evaluated six monthly or more frequently when clinically indicated. There is an activities programme across seven days. The programme is appropriate to the needs of older people with mental health conditions. There are also visits from community groups. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. The service is currently part of a pilot study into the use of an on line medication system. There is an improvement required around the signing of medication charts. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. There are food service policies and procedures and a link to a dietitian.

### **Outcome 1.4: Safe and Appropriate Environment**

Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. The building holds a current warrant of fitness  
Bupa Cornwall Park is a well maintained facility with a current warrant of fitness which expires 19-Oct-14. The facility is secure, warm with ample space for residents to mobilise. Exterior areas/gardens are well maintained and functional, and provide a safe and secure area for residents.

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

There are clear guidelines in policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has one resident on the register with an enabler in the form of bedrails. The resident file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. Training has been provided around restraint, enablers and challenging behaviours.

### **Outcome 3: Infection Prevention and Control**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections which have been completed in 2013 as per internal audit schedule.  
Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.



## Summary of Attainment

|                  | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| <b>Standards</b> | 0  | 13 | 0             | 2      | 1           | 0       | 0           |
| <b>Criteria</b>  | 0  | 38 | 0             | 2      | 1           | 0       | 0           |

|                  | UA Negligible | UA Low | UA Moderate | UA High | UA Critical | Not Applicable | Pending | Not Audited |
|------------------|---------------|--------|-------------|---------|-------------|----------------|---------|-------------|
| <b>Standards</b> | 0             | 0      | 0           | 0       | 0           | 0              | 0       | 34          |
| <b>Criteria</b>  | 0             | 0      | 0           | 0       | 0           | 0              | 0       | 60          |

## Corrective Action Requests (CAR) Report

| Code         | Name  | Description   | Attainment | Finding  | Corrective Action  | Timeframe (Days) |
|--------------|---|---|------------|--|--|------------------|
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low     |  |  |                  |
| HDS(C)S.2008 | Criterion 1.2.3.8                                   | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.       | PA Low     | Meeting minutes do not all reflect documented follow through of actions required to ensure these have been actioned, (ii) Two quality improvement alerts identified from head office that included action plans were not signed off as completed [25/9 and 11/10]. | Ensure meeting minutes reflect follow through of actions required, (ii) Ensure that head office quality alerts identify that corrective actions are addressed immediately. | 90               |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions      | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.   | PA Low     |  |  |                  |

| Code         | Name                                 | Description   | Attainment  | Finding   | Corrective Action  | Timeframe (Days) |
|--------------|--------------------------------------|---|-------------|---|--|------------------|
| HDS(C)S.2008 | Criterion 1.3.6.1                    | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.   | PA Low      | A short term care plan completed with the heading of Urinary Tract Infection contained a plan of care for an infected wound.  | Ensure that short term care plans accurately document the issue currently being addressed. | 90               |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.   | PA Moderate |   |  |                  |
| HDS(C)S.2008 | Criterion 1.3.12.1                   | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Eight of twelve medication signing charts reviewed evidenced gaps where prescribed medications were not documented as having been administered. Progress notes reviewed did not document any rationale why the medications had not been given/signed for. | Ensure medications are signed for at the time of administration.                           | 30               |

## Continuous Improvement (CI) Report

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

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

|   |
|---|
| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

Consumers are informed of their rights.

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

|   |
|---|
| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

|   |
|---|
| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |
| <b>Finding:</b>                         |

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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



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

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

ARHSS D16.5e

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

|  |
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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b> <p>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.</p> <p>One registered nurse and clinical manager interviewed stated that they record contact with family/whanau on the family/whanau contact record (sited). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for September identified that nine of 18 incident forms, identified that family were notified (the other nine incident forms had documented that family were not informed because they had requested notification for serious incidents only). As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in April 2013 at Cornwall Park with a result of 95.8%. 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.</p> <p>D16.4b The three relatives interviewed stated that they are always informed when their family members health status changes.</p> <p>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 Director - quality and risk and the consultant geriatrician.</p> <p>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.</p> <p>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 is a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available.</p> <p>D12.1 Non-Subsidised residents/EPOA are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry</p> |

'D11.3 The information pack is available in large print and advised that this can be read to residents.  
ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident's handbook providing practical information for residents and their families.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |
| <b>Finding:</b>                         |
| <b>Corrective Action:</b>               |

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

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints procedure (065) states 'The facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint summary record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to the Quality and Risk team via the facility benchmarking spreadsheet'. There is a complaints process flowchart. ARHSS D13.3g: The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint (nine written, three verbal). Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are encouraged and actions and responses are documented. Discussion with three relatives confirmed they were provided with information on complaints and complaints forms are available at the entrance. Two relatives described having concerns addressed immediately when brought up with management.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

## Outcome 1.2: Organisational Management

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b> <p>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. Cornwall Park has set specific quality goals for 2013 including (but not limited to); a) to further improve the internal environment, b) to reduce incidents of bruising and falls by 10%.</p> <p>Bupa Cornwall Park provides specialist hospital level care (psychogeriatric) for up to 39 residents. There was full occupancy on day of audit.</p> <p>Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.</p> <p>There is an overall Bupa business plan and risk management plan.</p> <p>The organisation has commenced a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. Three senior members of the Quality and Risk team are also members of the market unit, Australia/NZ clinical governance group</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.</p> |



Facility Manager provides a documented weekly report to Bupa Operations Manager. The operations manager visits regularly and completes a report to the General Manager Care Homes. Cornwall Park is part of the Northern 2 Bupa region which includes seven facilities. The managers in the region teleconference weekly, Quarterly quality reports on progress towards meeting the quality goals identified are completed at Cornwall Park and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals.

Cornwall Park continues to implement the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa Way has been launched in 2011 – the Bupa Way builds on former work that was done around the philosophy of care - 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 2011. The standardised care plan template 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 B-fit organisational goal is well implemented at Cornwall Park.

ARHSS D17.5 the manager has maintained at least eight hours annually of professional development activities related to managing a hospital. The Interim Manager has been in the role since Sept 13. She also manages another Bupa facility (Hillsborough) and described having alternate days in each facility. The FM is supported by a clinical manager. The manager has many years' experience in management and nursing in mental health and dementia. There are job descriptions for both positions that include responsibilities and accountabilities. 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.

ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

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

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

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

**Attainment and Risk:** PA Low

#### **Evidence:**

Cornwall Park 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, on the noticeboard 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 (sighted at Cornwall Park). 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 quarterly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected and staff incidents/accidents; b) The service has linked the complaints process with its quality management system; c) There is a quarterly IC committee at Cornwall Park. 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. d) Health and safety committee meets quarterly and 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 memos/warnings (link CAR 1.2.3.8). Annual analysis of results is completed and provided across the organisation. e) The facility restraint meeting meets quarterly and the Bupa regional restraint approval group meets six monthly.

There is an implemented internal audit programme. 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 Cornwall Park 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 Operations Manager which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Operations Managers monthly summaries).

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 over from 2012). On-going review of these objectives for Cornwall Park are documented in H&S meeting minutes.

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. Cornwall Park has set up a clinical focus group that focuses on reducing incidents. Minimising incidents of Bruising and falls are in track for meeting the 2013 goal.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> PA Low  |
| <b>Evidence:</b><br>Reports provided to quality committee (such as OSH, IC,) include areas identified for improvement and actions initiated. The robust quality gathering, analysis and reporting system identifies a number of improvements to service delivery since previous audit.<br>Corrective action plans are initiated where an area of concern is identified e.g. increase in pressure areas identified as being over the benchmark May, July and Sept. A corrective action plan was established August.<br>A clinical focus group also reviews incidents that are over the benchmark. A review of incidents and accidents and benchmarking data for example identified that bruises have been above the benchmark Jan- Sept 2013. The service has been focussing on minimising bruises, a corrective action plan established August including manual handling training by all staff.<br>Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented.<br>The policy – “Quality Indicator Analysis and Corrective Action Plans” is a guide for staff around corrective action plans. |
| <b>Finding:</b><br>Meeting minutes do not all reflect documented follow through of actions required to ensure these have been actioned, (ii) Two quality improvement alerts identified from   |

head office that included action plans were not signed off as completed [25/9 and 11/10].

**Corrective Action:**

Ensure meeting minutes reflect follow through of actions required, (ii) Ensure that head office quality alerts identify that corrective actions are addressed immediately.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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 also introduced a dedicated email address to send CAT ones to which is manned by more than one specific person.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.

Eighteen incident forms reviewed for September identified that all demonstrated clinical follow up by a registered nurse 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 (HDS(C)S.2008:1.2.4.2)**

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

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

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

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

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



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

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

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

**Attainment and Risk:** FA

### **Evidence:**

Register of registered nurse (RN) and enrolled nurse (EN) practising certificates is maintained at facility level. 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. Five files reviewed (clinical manager, registered nurse, two caregivers, and activity therapist) and 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 (three caregivers, one registered nurse) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the clinical manager 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 Qualified staff training day provided through Bupa that covers clinical aspects of care - eg. Dementia, Delirium and Care planning. There is evidence on RN staff files of attendance at the RN training day/s and external training.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings.

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

Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has recently approved and validated their professional development recognition programme (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 Cornwall Park, there are three RNs currently enrolled to complete their PDRP.

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

ARHSS D17.1: There are 23 caregivers who work at Cornwall Park. Twenty-one caregivers have completed the required dementia standards and two are new to the service and are yet to start.

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

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

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

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

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

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

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

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

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The wage analysis schedule is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours. The roster is flexible to allow for the increase of numbers of residents.

Bureau staff are used when necessary currently there is a few shifts being covered by Bureau RNs while another RN position is being advertised. There is an RN 24/7, plus the clinical manager five days a week. The RNs complete 12 hour shifts. Interviews with three caregivers (across morning and afternoon shift) confirmed that staffing numbers were satisfactory. Interviews with three relatives had no concerns about staffing levels.

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

All records pertaining to individual consumer service delivery are integrated.

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |
| <b>Finding:</b>                         |

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

### Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

ARHSS D4.2

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bupa Cornwall is a Psychogeriatric unit. There is an implemented admission role of caregiver policy, an admission role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.

The six files reviewed identified that an assessment was completed within 24 hours. All six files reviewed identify that the long term care plan is completed within three weeks. There is documented evidence that the care plans are reviewed by an RN and amended when current health changes. Four of six care plans evidenced evaluations completed at least six monthly. Two residents were not long enough in the service to undergo six monthly review.

ARHSS D16.6; The RN identified that two residents files with behaviours that challenge and these were reviewed. On admission, two weeks behaviour assessments were completed to assist with development of behaviour management plans. Behaviours in the two files were well documented, short term care plans were developed for

acute episodes of aggressive behaviour with evidence of regular evaluations. The two resident's files evidenced referral to and input from the Mental Health Services Older Persons Health.

There is sufficient information gained through the initial support plan, specific assessments, the short-term care plan, and the lifestyle plans in all files reviewed to guide staff in the safe delivery of care to residents. Activity assessments and the activities sections care plans have been completed by the activities coordinator. All six files have at least an initial physiotherapy assessment completed with on-going assessments as necessary. Three family members interviewed stated they were involved and consulted in the planning of care and at evaluation. Resident files included family contact records which were completed and up to date in all resident files sampled.

All six 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 seen the residents monthly. More frequent medical review was evidenced occurring in files of residents with acute conditions.

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.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery and this was observed by the auditor. A Manager's Report is completed daily by the RN on each shift highlighting any changes to resident's condition, changes to roster, complaints, or any other issues. All resident files reviewed identified integration of allied health and a team approach. The GP interviewed described effective communication processes between the nursing staff and doctor.

Resident files reviewed

Tracer

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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



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

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

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

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

Service delivery plans demonstrate service integration.

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> PA Low   |
| <b>Evidence:</b> <p>Residents' care plans are completed by the registered nurses. Care delivery and any changes in residents' condition reported is documented by the RN on each shift (evidenced in all six residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. This audit identified that improvements are required around the documentation of short term care plans.</p> <p>The three 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. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence and wound care products were sighted.</p> <p>ARHSS D16.5c; Six residents files reviewed were individualized, behaviour management also linked to resident goals. Education on challenging behaviour took place in April and July 2013 with a total of staff 16 attending. Resident behaviours were used as scenarios to discuss the management of challenging behaviours at Tool box talks.</p> <p>ARHSS D16.4; There is good specialist input into residents in the unit. A psychogeriatrician visits monthly, and the GP visits twice per week. Strategies for the provisions of a low stimulus environment could be described in interviews with staff.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment rooms are well stocked for use. Wound assessment and wound management plans are in place for 14 residents (16 wounds). Wounds include three grade II pressure areas, two chronic leg ulcers and 11 skin tears. The three residents with pressure areas have pressure relieving devices documented within their wound management plan, pressure relief monitoring charts/turning charts and have been referred to dieticians for nutritional assessments.</p> <p>The registered nurse and clinical manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse and registered nurses in 2013 have had specialized wound management training.</p> |

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. Continence management in-services and wound management training have occurred. The facility has registered nurse cover 24/7 and has a comprehensive 'in service' education programme and toolbox talks on areas identified as special interest. A physiotherapist is contracted 1 day per week. 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.

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

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

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| <b>Attainment and Risk:</b> PA Low   |
| <b>Evidence:</b><br>Short term care plans were evidenced in use for wounds and infections. Care plans were evidenced to be reviewed six monthly. |
| <b>Finding:</b><br>A short term care plan completed with the heading of Urinary Tract Infection contained a plan of care for an infected wound.  |
| <b>Corrective Action:</b><br>Ensure that short term care plans accurately document the issue currently being addressed.                          |
| <b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)                                     |

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

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

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

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| <b>Attainment and Risk:</b> FA  |
| <b>Evidence:</b><br>The activities officer provide activities in the lounge areas, gardens and also provide one on one input in residents rooms when required. The activities officer works 30 hours per week and has been in the role for two months, but has previous experience of working in aged care facilities in England. The caregivers at the weekend assist in the delivery of the activity programme to ensure there are activities provided seven days per week. ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered is included in the lifestyle care plan. The activity care plan is developed with the relative/whanau and this is reviewed at least six monthly. ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly and a weekly planner is displayed in large print. There are monthly themes. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc. |

The programme includes networking within the community. A record is kept of individual resident's activities and progress notes completed. Each resident has a 'map of life'. There is a wide range of activities offered that reflect the resident needs in a psychogeriatric setting. The programme is comprehensive and caters for the individual needs including diversional plans for challenging behaviours. The activity officer stated the facility does not have its own van for outings but has access to a mobility van each Tuesday for outings and described going out for picnics to the Marina and visiting other places of interest. The activities officer has another member of staff with her when going out on outings.

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br>The six monthly care plan evaluation describes progress against every goal and need identified in the care plan (sighted). Short term care plans are well utilised. Any changes to the long term care plan are dated and signed. Six care plans reviewed included handwritten updates to the plan as needs have changed. Care plans are evaluated six monthly more frequently when clinically indicated (two files for recent admissions evidenced six monthly evaluation was not yet due). Short term care plans were evidenced completed for wounds, weight loss, urinary tract Infection and chest Infection. ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission |

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

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

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

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

ARC D21 ARHSS D21

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |
| <b>Finding:</b>                         |

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service is trialling the Medichart online medication delivery system. This however has not yet gone “live”, therefore the RNs have been using the Medichart system to view medication charts but are signing for the administration of medications on medication signing sheets.

Advised by the regional manager that Medichart system was to have gone live but this had been delayed for another few days and its full implementation was imminent. RNs only administer medications, and each RN has a unique login allocated to them so that the Medichart system can identify who has signed in to administer medications. There is a written copy of all medication charts kept in medication folder.

The service uses individualized Robotics medication packs. The medications are delivered fortnightly and checked in by the RN on night duty and a verification form is signed. The pharmacy is notified of any errors. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications.

The lunch time medication round was observed. Medications and associated documentation is kept on the medication trolley in a locked treatment room. RN's deemed competent are responsible for administering medication. Medications are reviewed three monthly with medical reviews by the attending GP.

Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.

Controlled drugs are stored in a locked cabinet inside a locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Senior caregivers who have completed a second checker controlled medication competency check controlled medications with the RN. A stock check of controlled drugs is completed weekly. Medication fridges are monitored daily.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 12 drug charts reviewed. Allergies or nil known allergies are recorded on all medication charts reviewed.

There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available. There are no residents who self-administer medications.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. PRN medication orders all record indications for use.

There is an improvement required around signing for medications.



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

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

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| <b>Attainment and Risk:</b> PA Moderate  |
| <b>Evidence:</b><br>The service is trialling the Medichart online medication delivery system. This however has not yet gone “live”, therefore the RNs have been using the Medichart system to view medication charts but are signing for the administration of medications on medication signing sheets.<br>Advised by the regional manager that Medichart system was to go live but this had been delayed for another few days and its full implementation was imminent. RNs only administer medications, and each RN has a unique login allocated to them so that the Medichart system can identify who has signed in to administer medications. There is a written copy of all medication charts kept in medication folder. |
| <b>Finding:</b><br>Eight of twelve medication signing charts reviewed evidenced gaps where prescribed medications were not documented as having been administered. Progress notes reviewed did not document any rationale why the medications had not been given/signed for.   |
| <b>Corrective Action:</b><br>Ensure medications are signed for at the time of administration.  |
| <b>Timeframe (days):</b> 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)   |

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

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

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

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

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

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

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br>All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller, a freezer and a pantry. The menu is designed and reviewed by a Registered Dietitian at an organisational level. There is a six monthly rolling menu. All meals are cooked on site. There are also snacks available over 24 hours for residents. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and |

weekly. Food safety in-service education has occurred. There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets.

Food in fridges, freezer and pantry are labelled and dated. Decanted food is dated and time for rotation is recorded. Cleaning schedules are implemented.

Residents with special dietary needs have a nutritional profile completed on admission. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the kitchen notice board which is able to be viewed only by kitchen staff.

The service has three meal sittings to ensure that all residents receive a hot meal with assistance provided with feeding as identified in residents care plan and meal times are not rushed for residents.

There is a resident list in the kitchen and staff tick off when each resident has been served their meal.

One resident was observed during the audit to continually walk around the facility and was not noted to sit down. On discussion with the RN and Cook the resident refuses to sit for meals and continually will get up and walk away from the table. The cook reported that the resident loves sandwiches and finger foods and that she makes the resident egg and bacon sandwiches each morning for breakfast and that finger foods are provided for this resident to ensure a good nutritional intake. The resident was observed to be served a meal at lunchtime but got up from the table very soon after being served. The staff then put a selection of finger foods in a bowl for the resident to carry and the resident was observed walking and eating the foods from the bowl. The resident also is prescribed high calorie/protein drinks. Weight chart reviewed evidences the residents weight is stable.

Food intake charts are recorded for those residents identified at risk of malnutrition due to dementia/medical conditions. The clinical manager reviews resident's weights monthly to monitor for any weight loss/gain and implement appropriate interventions when required.

ARHSS D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours

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

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

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

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

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

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

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

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

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

**Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

### **Evidence:**

There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and were reviewed. Hot water temperatures are checked monthly and records show that they are maintained in a safe range. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires on 19-Oct-14.

There is a large lounge and separate dining area. There are quiet seating areas/lounges. The corridors are wide and allow for residents to mobilise with mobility aides, in wheelchairs with the assistance of a caregiver.

The external areas are safely maintained and are secure and appropriate to the resident group and setting and include seating and shade.

The three caregivers and registered nurse interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

### **Evidence:**

The building holds a current building warrant of fitness. Fire protection inspection services are responsible for the maintenance of fire equipment.

The main entrance has an external and internal secure access. Staff amenities and administration offices are located upstairs. There is a maintenance officer Monday to Friday and available on call for urgent matters. There are planned maintenance schedules for monthly (wheelchairs, nurse call system, external lights), two monthly (air filters, air conditioners), three monthly (sanitizers), six monthly (trolleys) and annual (external) maintenance checks. Hot water temperature monitoring is conducted monthly. Monthly monitoring forms sighted. Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and the sling hoist, electric bed and weighing scales were checked and serviced at this time.

The corridors are spacious and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

The furnishing and fixtures are appropriate to the consumer room. Seating is arranged to allow group and individual activities to occur.

The external areas are well maintained and gardens are attractive. There is easy access to secure and safe walking paths from each external door. Outdoor seating and shade is available. There is wheelchair access to all areas.

The 2012 quality goals included a goal for "to further improve internal and external facility areas- making hospital truly dementia friendly with best possible safe use of all areas. The following was implemented as a result of their goal; a) developed a circular grass patch area outside front deck at front of property with pond and quiet sitting area; b) created a ladies corner, c) created a second destination point – Pub on corner, d) third destination point – a shop developed on corner of the hallway and lounge area, e) raised beds on centre deck re planted with vegetables and strawberry plants

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |



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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

ARC E3.4b ARHSS D15.3d

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

ARC D15.2f ARHSS D15.2g

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br><p>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'.</p> <p>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</p> <p>The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has one bedrail as an enabler and two residents with T-belts as restraint. The file reviewed of the resident with an enabler included assessment, consent, interventions, monitoring and three monthly evaluations.</p> <p>There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is</p> |

reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

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| <b>Attainment and Risk:</b> Not Audited   |
| <b>Evidence:</b>  |
| <b>Finding:</b>   |
| <b>Corrective Action:</b>   |
| <b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |



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

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

Services use restraint safely

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** Not Audited

**Evidence:**

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

ARC D5.4e ARHSS D5.4e

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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

ARC D5.4e ARHSS D5.4e

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

ARC D5.4e ARHSS D5.4e

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| <b>Attainment and Risk:</b> Not Audited |
| <b>Evidence:</b>                        |



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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> Not Audited  |
| <b>Evidence:</b>   |
| <b>Finding:</b>  |
| <b>Corrective Action:</b>  |
| <b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br>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. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Infections remain low in 2013.

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

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

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

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

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

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

