

Bupa Care Services NZ Limited - Telford Rest Home & hospital

Current Status: 31 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

Telford is part of the Bupa group. The service is certified to provide rest home and hospital level care. The service has a capacity of 52 beds. On the day of the audit, there were 22 hospital residents and 24 rest home residents.

Telford hospital is managed by a registered nurse who has been in the position since May 2013. She has previously worked as a Facility Manager in another aged care home for five years. She is supported by a clinical manager. Residents and relatives interviewed spoke positively about the care provided.

Ten of 11 shortfalls identified at previous audit have been addressed including; advance directives, meetings, documentation timeframes, assessments, short term care plans, wound care documentation, medication management, enablers and restraint monitoring.

There continues to be improvements required around aspects of care planning documentation.

This audit identified further improvements required around aspects medication documentation.

Audit Summary as at 31 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 31 October 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 31 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 31 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.
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Safe and Appropriate Environment as at 31 October 2013

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.
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Restraint Minimisation and Safe Practice as at 31 October 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 31 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>
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HealthCERT Aged Residential Care Audit Report (version 3.9)

Introduction

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

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

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

Audit Report

Legal entity name:	Bupa Care Services (NZ) Limited
Certificate name:	Telford Rest Home & Hospital
Designated Auditing Agency:	HDANZ
Types of audit:	Surveillance
Premises audited:	Telford Rest Home & Hospital, 15 Telford Street, Merrilands, New Plymouth
Services audited:	Rest Home, Hospital and geriatric - medical
Dates of audit:	Start date: 31 October 2013 End date: 1 November 2013
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	46

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	12	Total audit hours off site	8	Total audit hours	20
Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	48	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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 Monday, 9 December 2013

Executive Summary of Audit

General Overview

Telford is part of the Bupa group. The service is certified to provide rest home and hospital level care. The service has a capacity of 52 beds. On the day of the audit, there were 22 hospital residents and 24 rest home residents.

Telford hospital is managed by a registered nurse who has been in the position since May 2013. She has previously worked as a Facility Manager in another aged care home for five years. She is supported by a clinical manager. Residents and relatives interviewed spoke positively about the care provided.

Ten of 11 shortfalls identified at previous audit have been addressed including; advance directives, meetings, documentation timeframes, assessments, short term care plans, wound care documentation, medication management, enablers and restraint monitoring.

There continues to be improvements required around aspects of care planning documentation.

This audit identified further improvements required around aspects medication documentation.

Outcome 1.1: Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Residents and Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The previous audit identified that advance directives were not correctly completed. A review of advance directives evidenced that this shortfall has been addressed.

Outcome 1.2: Organisational Management

Telford has an established quality and risk management system that supports the provision of clinical care and support. Policies and procedures are reviewed at least every three years and are updated to reflect best practice, legislation and standards. Discussions with staff and a review of meeting minutes demonstrate a culture of quality improvements. Key components of the quality management system link to the two monthly quality meetings.

An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings.

The service is active in analysing data. 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.

Comparisons for facilities within the benchmarking groups is provided as graphs and is available on the internal intranet. Quality action forms are utilised at Telford to document actions that have improved or enhanced a current process or system or actions that have improved outcomes or efficiencies in the facility. Health & safety is well managed at a facility and organisational level.

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. Discussion with staff and management confirmed that there is a comprehensive in-service training programme covering relevant aspects of care and support and the requirements.

There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes.

Outcome 1.3: Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Residents and relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess effectively level of risk and support required for residents. Short term care plans are in use for changes in health status. These are improvements implemented following shortfalls identified at the previous audit. Care plans are evaluated six monthly or more frequently when clinically indicated. Improvements are required by the service around aspects of care planning documentation, .

Activities are age appropriate and include 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 reviewed by the general practitioner three monthly or earlier if necessary. An improvement is required around medication documentation.

Residents' food preferences are identified at admission. 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

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Residents have adequate personal space. Resident rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. External areas are safe and well maintained.

Outcome 2: Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers that is congruent with the definition in the standards. Currently the service has four residents on the register with an enabler in the form a bed rail or lap belt for use when in electric wheel chairs. The service currently has three residents using bed rails assessed as restraint, one resident with a "T" belt used as a restraint and one resident with a low-low bed assessed as restraint. There is a restraint register that is maintained.

There is a restraint register in place. Restraint assessments are based on information in the care plan, discussions with residents and on staff observations of residents. Restraint is reviewed for each individual at least three monthly and as part of the six monthly multidisciplinary review. Reviews include family/whanau. Of the two previous findings around the restraint documentation, one continues to require continuing improvement and as it relates to interventions being documented in care plans has been identified in 1.3.5.2. The previous finding around restraint monitoring has been addressed.

Restraint usage throughout the organisation is monitored and benchmarked. Restraint benchmarking is available on the intranet each quarter. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Outcome 3: Infection Prevention and Control

The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Infection control training is provided at least twice each year for staff.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	0	2	0	0
Criteria	0	43	0	0	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	31
Criteria	0	0	0	0	0	0	0	56

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	One hospital resident file reviewed did not document the use of an enabler (bed rail) in the care plan. Progress notes reviewed for one rest home resident documented that the resident's sacrum was red and this had been reported to the RN. No documented RN follow up of this concern was evidenced as occurring until two days later when the resident had developed a broken area on sacrum.	Ensure care plans accurately reflect the interventions required to meet resident needs. Ensure RN follow up of concerns identified and documented by care givers in progress notes is completed by the RN on that day.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 1.3.12.6	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.	PA Moderate	(i) Four of ten medication charts reviewed did not contain photographic ID. (ii) Standing orders are not regularly reviewed by the GPs. One has not been reviewed by GP since 2010. (iii) Two faxed copies of medication charts were evidenced to be very difficult to read due to poor quality of print.	Ensure photographic ID is attached to medication charts (ii) Ensure standing orders are reviewed as per policy; (iii) Ensure medication charts are legible.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

Consumers are informed of their rights.

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: 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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

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

Attainment and Risk: 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 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

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

Attainment and Risk: 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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

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

Attainment and Risk: 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 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

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

Attainment and Risk: 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 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: 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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

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

Attainment and Risk: 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 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

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

Attainment and Risk: 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 1.1.6: 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.

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

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

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

Attainment and Risk: FA
Evidence:
<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>The two registered nurses and clinical manager interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed 33 of 36 identified that family were notified. (Three incidents were not related to residents.)</p> <p>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 on 18-Oct-13 with no corrective actions required.</p> <p>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>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.</p> <p>Residents' meetings are held monthly. Last meeting was held 03-Sept-13. (Meeting minutes sighted). Relatives meetings are held three monthly. The facility manager completes a resident's newsletter quarterly which is sent out to staff and relatives.</p> <p>A Resident Satisfaction Survey was completed in September 2013. Thirty nine surveys were sent out and 37 were returned. Overall satisfaction with the service is 91%.</p>

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

D16.1b.ii Residents and family interviewed confirmed that they are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement

D16.4 Four relatives interviewed stated that they are always informed when their family members health status changes.

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The previous certification audit identified that in the rest home one resident had no advanced directive form and no indication that advanced directive had been discussed with the resident and one resident had an NFR (not for resuscitation) with no signature from the resident or indication of discussion regarding this subject by the GP. In the hospital two of four advance directive forms had no indication this had been discussed with the resident or family.

This audit evidenced required consent forms and advance directive forms were in five resident files reviewed.

Discussions with two registered nurses and clinical manager identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

Completed resuscitation treatment plan forms were evident on all five resident files reviewed. Medical notes evidence discussion with residents and family where appropriate. Therefore the previous finding has been addressed.

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

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

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

Standard 1.1.12: 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence: <p>The complaints procedure (065) states 'The facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint 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 Quality and Risk team via the facility benchmarking spreadsheet'.</p> <p>There is a complaints flowchart. 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. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with seven residents (four rest home and three hospital) and four relatives confirmed they were provided with information on complaints and complaints forms. Fifteen complaints received to date in 2013 were reviewed. All were well documented including investigation, follow up letter and resolution. One complaint was evidenced to have been investigated by the DHB in August 2013. The complaint was evidenced to have been substantiated and has been resolved.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p>

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Telford is part of the Bupa group of facilities and provides care for up to 52 residents at hospital (geriatric and medical) and rest home level. On the days of the audit, there were 28 of 28 rest home residents and 22 of 24 hospital residents. There are currently no residents under the medical component of the certificate. Service appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. This includes an internal audit system to regularly assess service performance with its systems and communication of results to staff. The service is currently managed by a registered nurse who is an experienced Facility Manager who has been in the position at Telford since May 2013. She is supported by a Clinical Manager (acting) as the clinical manager is on maternity leave, and a regional manager.

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

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

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.

Telford continues to implement the "personal best" initiative whereby staff are 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 Telford.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Bupa Telford has an established quality and risk management system. Interviews with five caregivers, two registered nurses, facility manager and acting clinical manager and review of meeting minutes demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team.</p> <p>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.</p> <p>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.</p> <p>The document control policy (321) includes; a) responsibilities - policy development, b) approval of policies, c) responsibilities - policy implementation, d) document control register, e) document design, f) document properties, g) developing a new policy, and h) reviewing an existing policy.</p> <p>A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team.</p> <p>Finalised versions include, as appropriate, feedback from the committee and other technical experts. Policies and procedure documents are reviewed regularly. Policy review dates are monitored.</p> <p>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.</p> <p>This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing. Key components of the quality management system link to the quarterly quality</p>

committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality and risk team provide a coordinated process between service level and organisation. Weekly reports by facility manager to Bupa operations manager and quality indicator reports 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 across the rest home and hospital units and staff incidents/accidents; b) The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints; c) There is an infection control register in which all infections are documented each month. Infection control rates, outbreaks and results of satisfaction surveys are reported to the Quality and risk team. The general manager quality and risk is kept informed and is part of the governing body. There is an IC committee at Bupa Telford. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the quality, IC and staff meetings.

d) Health and safety committee meets monthly is also an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation.

e) The northern regional restraint approval group meets six monthly and the facility restraint group meets bimonthly. These meetings include a comprehensive review of restraint/enabler use. Restraint internal audit is completed annually.

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

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

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Bupa Telford and document actions that have improved outcomes or efficiencies in the facility. At the time of audit a number of quality improvements were either in place or had been completed these included; the development of a new admission booklet, new lighting installed in the facility, hallways repainted, Rest Home dining room has been redecorated, the entrance/foyer is being redecorated, update of the Emergency plan has been completed, a staff weekly newsletter has been developed, changes to the activities calendar have occurred and this contains more visual prompts for residents, the use of agency staff has decreased by 80% in the last three months, there has been a focus on the Bupa “B fit” programme with increased staff participation.

The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

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. The Bupa Health and Safety Plan objectives include the Bfit programme (for staff) and a reduction by 10% in staff injury. On-going review of these objectives is seen in the facility H&S meeting minutes.

D19.3 There is implemented risk management and health and safety policies and procedures in place including accident and hazard management.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

Criterion 1.2.3.9 (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: <p>The service collects incident and accident data. Category one incidents policy (044) states "The category one incident will be recorded on a standard accident/incident form. The form must provide: a clear account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence. 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 a dedicated email address to send CAT ones to.</p> <p>D19.3b; there is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. 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.</p> <p>33 of 36 incident forms were reviewed across the service and all demonstrated clinical follow up by a registered nurse and monitoring (such as neuro obs) having been undertaken when indicated. Three incidents were not resident related.</p> <p>D19.3c Bupa care services has a reportable event policy that sits with the category one (serious incidents) policy. This policy identifies the events that</p>

need to be reported, by whom and the process to follow. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Register of registered nurse (RN) and enrolled nurse (EN) practicing certificates is maintained at facility level and within Bupa website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Of seven reviewed files (acting clinical manager, one registered nurse, one activities coordinator, one cook, and three caregivers) 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 (five caregivers, one activities coordinator, one cook, two registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the facility 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.

There is an annual education schedule that is being implemented. In addition opportunistic education is provided by way of tool box talks - eg. Medication administration and documentation. There is a Qualified staff training day provided through Bupa that covers clinical aspects of care - eg. Delirium, Dementia, care planning etc. External education is available via the DHB. There is evidence on RN staff files of attendance at the Qualified staff 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.

The nursing Council of NZ has approved and validated the Bupa PDRP for five years. Bupa takes over the responsibility for auditing their qualified nurses. All nurses have commenced on the Nursing Council Approved PDRP to date.

D17.7d: There are implemented competencies for registered nurses related to specialised procedures e.g. catheterisation, PEG feeding, syringe drivers. Twenty eight staff have attained bronze certificate, 24 have attained silver and 17 have attained Gold in the Bupa Personal Best initiative.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The Bupa WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.</p> <p>The facility manager (RN) works Monday- Friday 40 hours per week and is available on call after hours.</p> <p>The clinical manager works Monday- Friday 40 hours per week.</p> <p>There is RN cover 24/7.</p> <p>Two of seven residents interviewed stated that staff are “always in a rush as there are so many residents who need assistance” gave their consent for this information to be passed on to the management.</p> <p>Five of seven residents interviewed felt there are enough staff on duty and that the call bells are answered promptly by staff.</p> <p>Caregivers interviewed stated that it is difficult when staff phone in sick at the weekends to get cover. When discussed further with the staff and manager, staff are replaced with own staff members or casual staff. A review of rosters evidenced adjustments to the roster to cover for staff sickness and annual</p>

leave. The facility is currently recruiting for another caregiver.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: 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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

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

Attainment and Risk: 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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

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

Attainment and Risk: 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 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:

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

Standard 1.3.2: 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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; D16.5cj; 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:

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.

D16.2, 3, 4: The five files reviewed (three hospital and two rest home) identified that an assessment was completed within 24 hours. Four of five files reviewed identify that the long term care plan is completed within three weeks. (One file is for a recent admission that has not been with the service for three weeks.) There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Four of five plans evidenced evaluations completed at least six monthly. One hospital resident was not long enough in the service to undergo a six monthly review. These are improvements that have been implemented following shortfalls identified at the previous certification audit.

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 five files have at least an initial physiotherapy assessment completed with on-going assessments as necessary. Residents interviewed (three hospitals and four rest homes) stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family/whanau contact records which were completed and up to date in all resident files sampled.

D16.5e: Five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and were to be reviewed three monthly. More frequent medical review was evidenced occurring in files of residents with acute conditions and residents receiving palliative care.

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. A manager's report is completed by the registered nurse on duty on each shift. 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 the GP and Practice Nurse.

Rest home files review included; one resident assessed with a wound and unintentional weight loss and one resident assessed as a high falls risk.

Hospital files reviewed included; one resident requiring the use of an enabler, one resident with challenging behaviour and one resident receiving palliative care.

Tracer Methodology:

Rest Home

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

Tracer Hospital

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The previous audit identified that a review assessment tools had not consistently occurred six monthly or sooner if required. This audit identified that the clinical manger has a schedule of all residents requiring review of care plans or assessment tools and that this schedule has been implemented and adhered to. A review of five file evidenced that assessments have been reviewed in four of five files (one was a recent admission) six monthly or sooner if there has been a change to the condition/needs.</p>

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The previous audit identified that care plans (lifestyle plans) did not document the required care as per the results of completed assessments or progress notes. This audit identified that improvements continue to be required and this finding has not been resolved.

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

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

Attainment and Risk: PA Moderate

Evidence:

Service delivery plans are comprehensive and demonstrate service integration and demonstrate input from allied health. Notes by GP and allied health professionals, significant events, communication with families and notes as required by RN. Lifestyle care plans are in place for all five resident files reviewed

Finding:

One hospital resident file reviewed did not document the use of an enabler (bed rail) in the care plan. Progress notes reviewed for one rest home resident documented that the resident's sacrum was red and this had been reported to the RN. No documented RN follow up of this concern was evidenced as occurring until two days later when the resident had developed a broken area on sacrum.

Corrective Action:

Ensure care plans accurately reflect the interventions required to meet resident needs. Ensure RN follow up of concerns identified and documented by care givers in progress notes is completed by the RN on that day.

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Residents' care plans are completed by the registered nurses. Care delivery is recorded by caregivers on each shift and follow up by registered nurses is documented for any changes in residents condition reported as sighted in progress notes reviewed. (link to 1.3.5.2) The registered nurse initiates a review and if required, GP or specialist consultation when there is a change in residents' condition.</p> <p>Residents are weighed monthly or more frequently as per GP instructions. The registered nurses review all residents' weights and identify any weight loss/gain and implement appropriate interventions as required including a short term care plan. This is an improvement implemented following previous audit outcome.</p> <p>The five 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 stored in the rest home and hospital wings.</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 four rest home residents. All wound pressure areas have pressure relieving devices documented within their wound management plan, pressure relief monitoring charts/turning charts and have been referred to GP. Nutritional assessments have been reviewed. An incident/ accident form was evidenced completed for a grade II pressure area for a hospital resident which occurred 26-Oct-13. The two registered nurses and clinical manager (CM) interviewed described the referral process and related form for referral to a wound specialist or continence nurse.</p> <p>The previous audit identified shortfalls regarding the documentation of wound care evaluation. This audit evidenced that wound care/treatment is evaluated as to progress towards healing as demonstrated on 10 wound care management plans reviewed.</p> <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-</p>

services occurred in February and July 2013. 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 two days per week, (12 hours), plus is available for a further four hours per week when required.

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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a Diversional Therapist who works Monday-Friday 10.00-15.30hrs in the rest home and an activities coordinator who works Monday-Friday 08.30-14.00hrs in the hospital. There are two volunteers. One assists with gardening and the other assists with the delivery of the recreational programme three days per week.</p> <p>The activities team provides activities in the lounge areas, gardens and also provides one on one input in resident's rooms when required.</p> <p>On the day of audit residents in the facility were observed being actively involved with a variety of activities. The programme is developed monthly and a weekly planner is displayed in large print. Residents also receive a personal copy. The activity calendar has been reviewed to include pictorial prompts for residents. 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 and family.</p> <p>Information from the social history taken is fed into the lifestyle plan and this is reviewed six monthly as part of the lifestyle care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in the rest home and hospital. Participation in all activities is voluntary. The programme is comprehensive and designed for the differing levels of cognitive and physical</p>

functions of residents and caters for the individual needs including diversional plans for challenging behaviours. Entertainers visit twice weekly. The men interviewed reported visiting a tractor farm and classic car exhibition. Residents described having afternoon tea at Elizabeth R (another local Bupa Aged care facility) and going out for lunch or a coffee at local cafes. There are weekly church services. The Catholic church visits their parishioners weekly and provides Holy Communion/Eucharistic services. There is an exercise programme to promote balance, reduce falls and maintain or improve residents' range of movement this is facilitated by the physiotherapist who reports that resident participation is good and the class is well attended. There is a bird cage in the conservatory and there is a family of ducks in the grounds which the residents have enjoyed observing.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: FA
Evidence:
There is at least a one- three monthly review by the medical practitioner. D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in care plans sampled. There is at least a three monthly medication review by the medical practitioner. There are short term care plans to focus on acute and short-term issues. Changes to the long term care plan are made as required and at the six monthly reviews if required. Examples of STCP's use included; infections, wounds, challenging behaviours, and unexplained weight loss. Evaluation of short term care plans was evidenced and this is an improvement implemented since the previous audit. ARC D16.3c: All initial care plans were evidenced to be evaluated by a registered nurse 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.

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

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

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: 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 1.3.12: 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:

Medication policies align with accepted guidelines. Medications are stored in locked trolleys in the treatment room in the hospital. Controlled drugs are stored in a locked cupboard in the locked treatment room in the hospital and two people (one being an RN), must sign controlled drugs out. The service uses two weekly robotic packs. There is an improvement required around having photographic ID attached to medication charts. The facility uses pharmacy generated medication charts. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.

There is a list of standing order medications that have been approved by the GP's; however there is an improvement required around the GPs reviewing the standing orders. Staff sign for the administration of medications on medication sheet. The three medication folders reviewed include a list of specimen signatures and competencies.

The registered nurses administer medications in the hospital wing. Senior caregivers who are 'medication competent' are responsible for medication administration in the rest home. Senior caregivers who have completed a medication competency second check controlled medication with the RN in the hospital. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medication management training was held in 2013. There are currently no residents self-administering medications

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name.

D16.5.e.i.2; Ten of twelve medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was signed. Two medication chart reviewed were for recent admissions. Medication audits are completed six monthly.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Six of ten medication charts contained photographic ID. Standing orders are in place for the various GPs that are involved with the service. Medication charts are updated by the GP when they visit or by the registered nurses faxing the medications charts to the GP surgery to be updated.

Finding:

(i) Four of ten medication charts reviewed did not contain photographic ID. (ii) Standing orders are not regularly reviewed by the GPs. One has not been reviewed by GP since 2010. (iii) Two faxed copies of medication charts were evidenced to be very difficult to read due to poor quality of print.

Corrective Action:

Ensure photographic ID is attached to medication charts (ii) Ensure standing orders are reviewed as per policy; (iii) Ensure medication charts are legible.

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.2 All of the kitchen team have completed food safety certificates. There are two cooks. One works Monday-Friday and the other works weekends. The service has a large workable kitchen that is well equipped. There is a preparation area and receiving area. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. There is a resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. A food service audit conducted in May 2013 attained a score of 100%. There is a nutrition - assessment and management policy (347) and a weight management policy (079). An audit of resident weights was completed in February 2013 which attained a score of 98%.

Resident's weights are monitored monthly or more frequently as directed by GP.

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

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

Daily temperature checks of chiller, freezers, Bain Marie and dishwasher are maintained.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

Outcome 1.4: 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Standard 1.4.2: 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: <p>There is a maintenance person who works a total of 25 hours per week and on call. There is a volunteer who helps with the gardening. Reactive and preventative maintenance occurs. There is a Maintenance Log book kept in the staff room for staff to document any repairs, faulty equipment requiring attention and these requests are signed off by the maintenance person when completed. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 20-Jul-14. Records sighted evidence that electrical equipment is checked annually and was last completed in September 2013. The maintenance person interviewed reports that medical equipment was calibrated by BV medical in June 2013 and all hoists and electric beds were checked and serviced at this time. (Records were sighted). The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen/dining areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>Some residents use electric wheelchairs and were observed mobilising around the facility.</p> <p>The external areas are well maintained and gardens are attractive. There is garden furniture and plenty of shade. There is wheelchair access to all areas. Caregivers (five), two RNs and one CM interviewed reported that there are good resources available including; standing and full sling hoists, shower chairs, shower trolley/bed, pressure relieving mattresses, transfer belts, slippery sams, pressure relieving cushions, special pressure relieving chairs and specialist crockery and cutlery. Staff reported that if there is a need for equipment identified it is acted upon and obtained by the manager. There is a transportation policy and driver's licenses are checked. The facility has a van available for transportation of residents. Those transporting residents hold a current license and first aid certificate. The maintenance person completes a monthly safety check/audit of the facility van.</p>

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: 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 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: 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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: Not Audited

Evidence:

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

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

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

Standard 1.4.6: 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There is a Regional Restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has four residents on the register with an enabler in the form a bed rail or lap belt for use when in electric wheel chairs. The files reviewed of two residents identified as having an enabler in the form of a bedrail included a comprehensive enabler assessment that covered alternatives and least restrictive options however the use of an enabler was not documented in one of two residents care plans reviewed. This was a shortfall identified in the previous audit and has been documented in 1.3.5.2.

The service currently has three residents using bed rails assessed as restraint, one resident with a "T" belt used as a restraint and one resident with a low-low bed assessed as restraint. A register for each restraint is also completed that includes a monthly evaluation.

Two files reviewed of residents requiring the use of a restraint evidenced a comprehensive assessment/consent completed. Evaluation of the continued need for the restraint is evaluated at monthly restraint meetings and at six month care plan review. Monitoring of both enabler and restraints was evidenced occurring 2 hourly when enabler or restraint is in use. (Monitoring forms sighted).

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

Minutes of monthly restraint meeting which occurred in October 2013 were sighted. Staff education on the use of restraint occurred from 22-29 August 2013.

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.

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

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

Attainment and Risk: 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 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The previous certification audit identified that a residents care plan did not include any interventions related to the risks of the T belt including how often to monitor. There were no completed monitoring charts for the T belt during the day, however the monitoring chart was being completed for the resident at night when a bedside was in place.

This surveillance audit evidenced that interventions documented in restraint files reviewed documented the risks related to the use of the restraint and the frequency of monitoring. One file of a resident requiring the use of a lap belt and bedrail was reviewed evidenced that the use of the lap belt was monitored (monitoring charts sighted) during the day and the bed rail was monitored when in use overnight. Therefore this finding has been addressed.

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

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

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

Attainment and Risk: 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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;

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

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

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

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

Attainment and Risk: 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 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.

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

There are standards for infection control practice – cleaning, food service, linen service, and waste management. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

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

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

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

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

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

Attainment and Risk: 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.)*