

Bupa Care Services NZ Limited - Glengarry Rest Home & Hospital

Current Status: 21 November 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

Glengarry Rest Home and Hospital is part of the Bupa group. The service provides hospital (geriatric and medical), rest home and dementia level care. The service has a capacity of 41 residents. On the day of the audit, there were eight hospital residents, 17 rest home residents and five residents in the dementia unit. An experienced manager, who is a registered nurse that has been in the role at Glengarry for over three years, manages Glengarry. A Bupa operations manager also supports her. This audit has also assessed the suitability of dividing the current nine bed dementia unit into two separate units (a five bed dementia unit and a four bed psychogeriatric (PG) unit).

The service three previous audits (certification and two verification audits) identified 14 shortfalls. Eleven of these shortfalls have been addressed. Improvements continue to be required around a code of compliance for the new hospital building, advance directives, and aspects of interventions provided.

This audit identified further areas for improvement around aspects of medication management, wound documentation, regular reviews by the general practitioner, and securing the door between the dementia unit and the proposed new psychogeriatric unit.

Audit Summary as at 21 November 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 21 November 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.
--	--	--

Organisational Management as at 21 November 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.
---	--	--

Continuum of Service Delivery as at 21 November 2013

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

Safe and Appropriate Environment as at 21 November 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Restraint Minimisation and Safe Practice as at 21 November 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.
---	--	--

Infection Prevention and Control as at 21 November 2013

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

HealthCERT Aged Residential Care Audit Report (version 3.91)

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:	Glengarry Rest Home & Hospital
Designated Auditing Agency:	Health and Disability Audit NZ
Types of audit:	Surveillance
Premises audited:	Glengarry Rest Home & Hospital, Glengarry Place, Wairoa
Services audited:	Hospital, rest home, dementia
Dates of audit:	Start date: 21 November 2013 End date: 21 November 2013
Proposed changes to current services (if any):	
	The service proposes to divide the current nine bed dementia unit into two separate units; a four bed psychogeriatric unit and a five bed dementia unit.
Total beds occupied across all premises included in the audit on the first day of the audit:	30

Audit Team

Lead Auditor	XXXXX	Hours on site	7	Hours off site	4
Other Auditors	XXXXX	Total hours on site	7	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	14	Total audit hours off site	9	Total audit hours	23
Number of residents interviewed	4	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	8	Total number of staff (headcount)	37	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	3			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 has finished editing the document.	Yes

Dated Friday, 20 December 2013

Executive Summary of Audit

General Overview

Glengarry Rest Home and Hospital is part of the Bupa group. The service provides hospital (geriatric and medical), rest home and dementia level care. The service has a capacity of 41 residents. On the day of the audit, there were eight hospital residents, 17 rest home residents and five residents in the dementia unit. An experienced manager who is a registered nurse that has been in the role at Glengarry for over three years manages Glengarry. A Bupa operations manager also supports her. This audit has also assessed the suitability of dividing the current nine bed dementia unit into two separate units (a five bed dementia unit and a four bed psychogeriatric (PG) unit).

The service three previous audits (certification and two verification audits) identified 14 shortfalls. Eleven of these shortfalls have been addressed. Improvements continue to be required around a code of compliance for the new hospital building, advance directives, and aspects of interventions provided. This audit identified further areas for improvement around aspects of medication management, wound documentation, regular reviews by the general practitioner, and securing the door between the dementia unit and the proposed new psychogeriatric unit.

Outcome 1.1: Consumer Rights

Glengarry Rest Home and Hospital provides care and support that focuses on the individual with residents and relatives praising the services provided. Family state that they are informed of any incidents. Complaints processes are implemented and complaints and concerns are actively managed and documented with a complaints register completed.

Outcome 1.2: Organisational Management

The facility manager has extensive experience in aged care facilities as a registered nurse and provides clinical leadership and operational management. A regional manager also provides support. There is a registered nurse on each shift in the hospital/rest home area and staff complete the orientation programme and training as per the annual plan. Staff in the dementia unit have completed or are training in dementia.

The service has a quality and risk management programme implemented. Head office review policies and procedures with input from staff at various facilities the facility manager and quality data is collected, evaluated and used for quality improvement. This includes incidents/accidents; hazards; internal audits; infections; complaints and concerns; and resident/family satisfaction surveys. An internal audit schedule is implemented.

Improvements required at the previous audit around registered nurse cover and training for dementia have been addressed.

Outcome 1.3: Continuum of Service Delivery

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around regular reviews by GP's, two hourly turns, weight loss management and wound management. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There are improvements required around signing sheet documentation, as required medication prescribing and competency assessments for residents who self-administer medicines. The activities programme is facilitated by an activities officer and residents and families report satisfaction with the activities programme. The programme includes significant community engagement including visits from national performers doing concerts in the area. The activities coordinator develops an activities plan for the dementia unit and caregivers mostly implement this. All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the menu plans.

Outcome 1.4: Safe and Appropriate Environment

The building holds a current warrant of fitness. All wings and operational areas in the service are fully functional and the dementia unit is secure from the rest of the facility with a locked door and secure fencing. The external landscaping is completed in all areas including in the dementia unit. The maintenance programme ensures all buildings, plant and equipment are maintained to an appropriate standard or specification where a standard exists. Residents are able to bring in their own possessions. The dementia unit is a secure unit with safe and secure outside area that is easy to access. The current nine bed dementia unit is to be divided into a four bed psychogeriatric unit and a five bed dementia unit. The two units are already divided by double doors, which the facility manager states will be locked with a key pad. Each unit has a small lounge and dining area and each has access to a separate garden area. Access to the new psychogeriatric (PG) unit will be via the dementia unit. The two units will share one shower in the dementia unit with residents from the psychogeriatric unit being accompanied by a staff member from that unit when showering and a further staff member remaining in the psychogeriatric unit. Previous improvements required to separation of the dementia unit from the rest home/hospital, paths in the hospital area, dementia courtyard landscaping, recording of hot water temperatures, fire training, fire evacuation plan and the call bell system have been addressed. The previous requirement around the code of compliance for the hospital/rest home wing remains.

Outcome 2: Restraint Minimisation and Safe Practice

There are no restraints used and two enablers in use. There are consent forms and assessments completed for the residents using enablers. All staff have had training around management of challenging behaviours, restraint and enablers and are able to describe strategies to manage any challenging behaviour.

Outcome 3: Infection Prevention and Control

Infection control policies and procedures are documented. The infection control co-ordinator (registered nurse/facility manager) is responsible for

implementing the infection control programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	1	2	0	0
Criteria	0	43	0	1	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	55

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)One resident file sampled was for a resident requiring two hourly turns. The turning chart indicates turns have not occurred two hourly. The sample was increased by another two turning charts and these also show two hourly turns have not always been documented as occurring. (ii) One resident file sampled is for a resident who has lost significant amounts of weight. This resident was reviewed by a dietitian in January 2013 and the dietitian interviewed she should be	i)Ensure residents requiring two hourly turns are turned two hourly and that this is documented. (ii) Ensure residents with significant weight loss have on-going review by the dietitian and GP regarding this. (iii) Ensure residents prescribed nutritional supplements receive these as prescribed. (iv) Ensure that care plans are accurate and include interventions for all identified	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>seen again in two months. This has not occurred despite the resident having lost a further nine kilograms since July 2013. The GP has also not documented any comment about weight since January 2013. (iii) This resident is prescribed Ensure BD but a review of the medication chart shows this is not being regularly documented as having been administered. The sampled was extended to include a further five residents prescribed ensure and all five medication charts indicate ensure is not being given to residents as prescribed. (iv) The same resident does not have two hourly turns, the need for a puree diet or the management of diabetes included in the care plan. (v) One resident with four wounds has all four wounds on one assessment, plan and review so it is difficult to differentiate which documentation applies to which wound. (vi) Two of the nine current wounds including one pressure area have not been reviewed within stated timeframes.</p>	<p>needs. (v) Ensure all wounds have an individual assessment, management plan and review documentation. (vi) Ensure all wounds are reviewed within stated timeframes.</p>	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal,	PA Moderate	i)Three of eight medication charts sampled have PRN medications documented that do not include indications for use. (ii) Three of eight medication charts sampled have instances where regular	i)Ensure all PRN medication prescriptions include indications for use. (ii) Ensure medications are administered as prescribed.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications have not been signed as administered.		
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	(i)The key pad is not yet on the doors separating the dementia and psychogeriatric units. ii) A Code of Compliance for the hospital/rest home wing has not yet been issued.	(i)Ensure that the dementia unit and PG unit can be separate by a locked door. ii) Ensure that the hospital/rest home has a Code of Compliance.	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy around open disclosure. There is an interpreter policy that includes references to resources.

Contact with family members following an incident is recorded on the accident/incident form (documented in all of the 15 incident forms reviewed) and in resident files reviewed. In addition, contact with the family is recorded in the progress notes.

Three caregivers interviewed (two hospital / rest home and one dementia unit), the registered nurse and the facility manager (registered nurse) interviewed confirm that family are informed of any resident accidents or incidents.

There are no residents currently requiring interpreting services although some residents in the dementia unit revert to te reo particularly one resident who has lately reverted more and more to te reo. There are staff who can converse with her in te reo and the key caregiver in the morning interviewed states that she has written down phrases and can converse with her as observed during the audit.

D16.4b Three of three family members including one hospital, one rest home and one dementia confirm that there is good communication with the service and all state that they are informed of any incidents.

Four of four residents interviewed including three rest home and one hospital confirm that they are communicated with well.

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.

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

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

Newsletters are sent out and distributed throughout the year.

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 audit identified that some residents did not have resuscitation treatment plans and that resident competency to complete an advance directive was unclear. The four resident files sampled (two rest home, one dementia unit and one hospital) all clearly date the resident's competence (or not) to make an advance directive and all contain a resuscitation or not for resuscitation plan completed by the competent resident (in two files) or the GP with documented family consultation (in two files). The previous shortfall has now been addressed.

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

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

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

Attainment and Risk: FA
Evidence: <p>Bupa, including Glengarry Rest Home and Hospital has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained with all complaints documented for 2013 (2012 archived) and the register and folder shows investigation of all complaints, dates and actions taken for resolution. A complaint from family was tracked for monitoring purposes and the review identifies that the complaint is resolved in a timely manner with communication to the family documented. The support person for the family came to the feedback meeting facilitated by the facility manager and indicates that the family is happy with the result.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint (no use of restraint in the dementia unit), behaviour management and implementation of the complaints policy.</p> <p>Three of three family members including one hospital, one rest home and one dementia unit family member and residents interviewed (three hospital and one rest home) confirm that they know how to make a complaint and all state that there is no reason for them to make a complaint but feel that any concerns would be resolved if they were raised. All state that the service is 'excellent'.</p> <p>A complaint in 2012 was lodged with the Health and Disability Commission (HDC) and an email from the complaints assessment manager, HDC on 26 June 2013 confirms that 'the complainant no longer wishes to proceed with the complaint and the commissioner has therefore decided to take no further action'.</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:

Glengarry is part of the Bupa group of facilities and provides care for up to 41 hospital, medical, dementia and rest home residents (the 41 beds includes nine dedicated rest home beds, 23 hospital/rest home beds and nine dementia beds). On the day of the audit, there are 30 residents including 17 rest home residents, eight hospital residents and five residents requiring dementia level care at Glengarry Rest Home and Hospital.

Bupa's overall vision is "Taking care of their lives in our hands". There are six key values that are displayed on the wall. There are nine resident rooms form a secure dementia unit and the unit opened in mid February 2013 when final furnishings were put in.

The staff, quality and health and safety meeting minutes reflect discussion of the philosophy of care - person centred care. Bupa has appropriate management systems, policies, procedures, codes of practice and guidelines that are implemented and maintained at Glengarry Rest Home and Hospital.

An experienced facility manager (registered nurse) who has been in the role for three years manages the service. The facility manager has a history with the service including manager of the facility in 2005 for two years, relieving registered nurse in 2009 and manager of the facility from June 2010 to now. Bupa provides a comprehensive orientation and training/support programme for their managers. A team of registered nurses who provide support 24 hours a day, seven days a week supports her.

ARC,D17.3di (rest home), D17.4b (hospital) The manager has maintained at least eight hours annually of professional development activities related to managing a hospital, rest home and dementia unit including attendance at the Bupa conference, CareerForce moderation training, first aid and training at management meetings e.g. around managing behaviours, conflict resolution, HR management, health and safety.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The staff meeting minutes reflect discussion of the philosophy of care - person centred care.

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): <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
Evidence: <p>Glengarry Rest Home and Hospital has a documented quality and risk management system that is overseen by the facility manager with reporting to head office. There are annual quality goals (two set around performance appraisals and integration of staff into the dementia unit) that are reviewed two monthly. Quality improvement alerts are sent from the director of quality and risk to the service when issues are identified nationally. This is used to check practice and to improve if necessary.</p> <p>There are quality action forms completed and these identify improvements as they arise with evidence of outcomes and evaluation documented.</p> <p>Discussions with the facility manager, registered nurse, three caregivers and review of meeting minutes demonstrates staff involvement in quality and risk activities. Meetings include monthly staff and quality meetings, two monthly health and safety and infection control meetings and two to three monthly resident/family meetings (minutes sighted).</p> <p>There are regional meetings for the cook (monthly teleconference), restraint (six monthly), infection control (at least annually) and two monthly on site regional activity coordinator meetings.</p> <p>Annual resident and relative surveys are undertaken with the last collated in August 2013 with an 85% satisfaction. The service has improved the food services e.g. with the introduction of individualised menus in response to the feedback from the survey.</p> <p>D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed through Bupa head office with input from staff at various facilities. The quality and risk system is documented and links with associated policies/procedures. Clinical policies and procedures are in place for the rest home, dementia unit and hospital. There is a document control process implemented that includes a review date and sign off by head office.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is addressed through the quality improvement, health and safety and infection control monthly meetings as well as discussion as relevant at the staff meetings. A hazard register is documented and hazard identification forms identify that any hazards are addressed in a timely manner and discussed at meetings. There is a risk management plan that is reviewed at regular intervals.</p>

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

D19.2g Falls prevention strategies such as staff supervision, use of sensor mats, and no restraint used and a review of any incidents around falls are implemented.

Staff interviewed including the three caregivers (one from each unit) and registered nurse indicates that they are involved in the quality programme and this gives them an opportunity to identify any issues, discuss quality and to make suggestions.

Key quality improvements focused on in the last year have been around the setting up of the dementia unit, training for staff around dementia, food services, refurbishments of the offices and replacement of flooring in the hospital/rest home and the purchase of a new washing machine.

There is an implemented internal audit programme, all audits identify corrective actions required, and these are documented with sign off of resolution in a timely manner.

Discussion of audits and any corrective actions occurs through the quality, health and safety, staff and infection control meetings held one to two monthly depending on the frequency of the meeting documented in the policy.

There is a weekly report completed by the facility manager (sighted for September, October and November 2013).

There is a Bupa benchmarking programme with clinical and non clinical indicators monitored and facility performance measured against these. Clinical indicators include skin tears, acute wound infections, bruising, pressure sores, MRSA/ESBL, resident behaviour, infections. If an area of concern is identified (where the rate is more than 3 points above the group KPI), then further analysis is completed. The monthly quality indicator reports for Glengarry Rest Home and Hospital are completed with actions taken when required. These are reviewed by the facility manager for trends and any variances with actions taken as needed.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: 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 identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH. 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. A review of 15 incident reports in October 2013 indicate that recordings are taken when required and an ambulance is called when needed. Meeting minutes from the quality, health and safety, staff and infection control meetings reflect discussions of incidents/accidents and actions taken.

A review of incident/accident forms for Glengarry Rest Home and Hospital (15 reviewed) identifies that all 15 incident forms are fully completed and include follow-up actions taken.

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

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

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

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 1.2.7: 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:

A register of registered nurse, enrolled nurse, doctor, podiatrist, dietician, pharmacist practising certificates are kept within the facility indicating that all relevant staff and other health professionals have a current APC.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one registered nurse, two caregivers, one cleaner and one cook) include relevant induction books, referee checks, training, and development records.

Glengarry Rest Home and Hospital have in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to the service noting that the programme includes management of challenging behaviour and care of residents with dementia.

E4.5f There is a training programme and seven of the 22 caregivers including some staff who work in the dementia unit have completed their dementia qualifications. All others are enrolled in the dementia training. There are two registered nurses, one laundry, one cleaner and the activities coordinator who have also completed the dementia training. This is an improvement since the previous audit.

There is an implemented education plan (sighted for 2013) and this is well implemented. The annual training programme well exceeds eight hours annually.

Annual formal performance reviews are in place for reflective practice and setting goals including up skilling or other training or qualification and all five files reviewed include a current performance appraisal.

D17.7d: There are implemented competencies for staff relating to specialised procedures or treatment including medication competency, restraint competency and syringe driver, wound management, moving and handling of residents, insulin, and oxygen competency as relevant.

Registered nurses are supported to maintain their professional competency. Employee training records are maintained.

E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

Five of five staff files include a job description.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The wage analysis schedule is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support including the dementia unit.

Rest home/hospital/medical for 25 residents currently:

AM: Registered nurse 0700 - 1500, 1x caregiver 0700 - 1500, 1x caregiver 0830 - 1300, 1x caregiver 0700 -- 10.30.

PM: Registered nurse 1500 - 2300, 1x caregiver 1500 - 2300, 1x caregiver 1500 - 1930, 1x caregiver 1600 - 1830.

Night: 1x registered nurse 2300 - 0700, 1x caregiver 2300 - 0700.

Dementia unit (five residents currently): AM: 1x caregiver 0700 - 1500. PM: 1x caregiver 1500 - 2300. Night: 1x caregiver 2300 - 0700.

The manager works Monday to Friday 40 hours (flexi hours) and is on call. She works on the floor when required and lives three minutes away should staff need to call.

For the proposed division of the dementia unit into a four bed psychogeriatric unit and a five bed dementia unit, staffing will be as follows:

Dementia unit: One caregiver 24 hours a day.

Psychogeriatric unit: One caregiver 24 hours a day.

The facility's registered nurse will be based in the psychogeriatric unit for morning and afternoon shifts and if the registered nurse were required in the rest home or hospital, another staff member from these areas would relieve in the psychogeriatric (PG) unit. This means that there are always two in the PG unit at all times on PM and AM shift. On night shift, there will always be one caregiver and in event that a resident needs showering overnight (note that the shower is in the dementia unit), then the registered nurse or the other caregiver from the rest home hospital unit will provide support.

Improvements required to registered nurse cover 24 hours a day have been addressed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

In four of four resident files sampled (two rest home, one dementia unit and one hospital) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission by the GP in four of four files sampled and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person.

Activity assessments and the activities sections care plans have been completed by the activities officer.

Four residents interviewed (one hospital and three rest home) stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed and up to date in four resident files sampled.

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

D16.5e: Four resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. However three of four files sampled show that three monthly reviews have not always occurred. The facility manager explained that an internal clinical file audit in June 13 noted this short fall and interventions were implemented to address this. There have been no further gaps since that time.

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. Four files identified integration of allied health and a team approach is evident in the four files. The GP interviewed spoke positively about the service and describes very effective communication processes. All four files have at least an initial physiotherapy assessment with on-going assessments as necessary.

Tracer Methodology hospital resident:

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

Tracer Methodology rest home resident:

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

Tracer Methodology dementia unit resident:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: PA Moderate
Evidence: <p>Residents' care plans are completed by the registered nurses in all three areas. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all four residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The three caregivers interviewed (one from the dementia unit and two from the rest home/hospital) 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. The registered nurse interviewed stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Four residents interviewed (one hospital and three rest homes) and three families interviewed (one from the dementia unit, one from the rest home and one from the hospital) were complimentary of care received at the facility. The care being provided is consistent with the needs of residents, this is evidenced by discussions with three caregivers, three families interviewed, one registered nurses and the facility manager. There is a short-term care plan that is used for acute or short-term changes in health. The previous audit identified that not all identified areas of need were addressed in care plans. For this audit, four resident files were sampled and one does not have two hourly turns, the need for a puree diet or the management of diabetes included in the care plan.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. One resident file sampled was for a resident requiring two hourly turns. The turning chart indicates turns have not occurred two hourly. The sample was increased by another two turning charts and these also show two hourly turns have not always occurred. One resident file sampled is for a resident who has lost significant amounts of weight. This resident was reviewed by a dietitian in January 2013 and the dietitian interviewed she should be seen again in two months. This has not occurred despite</p>

the resident having lost a further nine kilograms since July 2013. The GP has also not documented any comment about weight since January 2013. (The resident was seen by the GP in July, who documented the area of most concern was the on-going falls). This resident is prescribed Ensure BD but a review of the medication chart shows this is not regularly being signed for as administered. The sampled was extended to include a further five residents prescribed Ensure and all five medication charts indicate Ensure is not being regularly documented as having been given to residents as prescribed. These are areas requiring improvement.

Wound assessment and wound management plans are in place for six residents. This includes two pressure areas. Two of the six wounds including one pressure area have not been reviewed in the timeframe stated and this is also an area requiring improvement. One resident has four wounds and all are included on one assessment, plan and review sheet, making it difficult to distinguish between the wounds. This is an area requiring improvement.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

The facility has registered nurse (RN) cover 24/7 and has an 'in service' education programme.

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

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: PA Moderate

Evidence:

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

Finding:

(i) One resident file sampled was for a resident requiring two hourly turns. The turning chart indicates turns have not occurred two hourly. The sample was increased by another two turning charts and these also show two hourly turns have not always been documented as occurring. (ii) One resident file sampled is for a resident who has lost significant amounts of weight. This resident was reviewed by a dietitian in January 2013 and the dietitian interviewed she should be seen again in two months. This has not occurred despite the resident having lost a further nine kilograms since July 2013. The GP has also not documented any comment about weight since January 2013. (iii) This resident is prescribed Ensure BD but a review of the medication chart shows this is not being regularly documented as having been administered. The sampled was extended to include a further five residents prescribed ensure and all five medication charts indicate ensure is not being given to residents as prescribed. (iv) The same resident does not have two hourly turns, the need for a puree diet or the management of diabetes included in the care plan. (v) One resident with four wounds has all four wounds on one assessment, plan and review so it is difficult to differentiate which documentation applies to which wound. (vi) Two of the nine current wounds including one pressure area have not been reviewed within stated timeframes.

Corrective Action:

i) Ensure residents requiring two hourly turns are turned two hourly and that this is documented. (ii) Ensure residents with significant weight loss have on-going review by

the dietitian and GP regarding this. (iii) Ensure residents prescribed nutritional supplements receive these as prescribed. (iv) Ensure that care plans are accurate and include interventions for all identified needs. (v) Ensure all wounds have an individual assessment, management plan and review documentation. (vi) Ensure all wounds are reviewed within stated timeframes.

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an activities coordinator who works 30 hours per week. The activities coordinator provides activities in the hospital and rest home and plans activities for the dementia unit, most of which are run by the caregivers. The activities coordinator has training around dementia care and needs. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. Caregivers were witnessed to provide a varied programme in the dementia unit. The programme is developed monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.

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

The programme includes networking within the community with social clubs, schools etc. On or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept individual residents activities. There are recreational progress notes in the resident's file that the activity officer completes for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in all areas of the facility, participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs. Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit, which are conducted by care staff out of normal hours. There is a resource cupboard in the dementia where caregivers (or visitors) can access activities to complete with residents. The activities coordinator has attended Bupa training around providing activities in a dementia unit.

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

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: Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. Care plans are evaluated by the registered nurses six monthly or when changes to care occur as sighted in four of four files sampled (one from the hospital, two from the rest home and one from the dementia unit). 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. From the sample group of resident's notes the short term care plans are well used and comprehensive. Examples of STCPs in use included; infections, wounds, challenging behaviours, and unexplained weight loss. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. ARC: ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

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

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

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): (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: <p>Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the two wings (currently the hospital and rest home are combined). Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Regular weekly controlled drug checks have occurred. Registered nurses or senior caregivers administer medications who have passed their competency administer medications.</p> <p>The service uses four weekly robotic packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy.</p> <p>Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies. Three of eight medication charts sampled have instances where regular medications have not been signed as administered and this is an area requiring improvement.</p> <p>Registered nurses are peer reviewed annually and caregivers are selected by the facility manager and trained in medication administration and competency checked annually. Only those staff deemed competent administer medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off. All 'medication competent' staff are responsible for medication administration in both areas. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers</p> <p>Medication management training was held in April 2013.</p> <p>Medication – self-administration policy (098) states self –administration of medication will be documented in the residents care plan.</p> <p>There is currently one resident self-administering at Bupa Glengarry and a competency assessment has been completed.</p> <p>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.</p> <p>The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the residents' general practitioner at least three monthly. Charts are easy to read and current. Medication audits are completed six monthly.</p>

There is a quality goal at an organisational level to reduce the use of antipsychotics. Advised this is progressing with currently only 7% of the facilities total residents being on an antipsychotic medication. This includes PRN medication and they are monitoring their residents to enable them to remove the medication completely. The service is well below the benchmark identified by Bupa and the service continues to actively work to reduce this with all residents using antipsychotics have an antipsychotic use plan to actively reduce antipsychotic use.
 Seven of eight charts sampled have PRN medications charted with no indication for use documented. This is an area requiring improvement.
 D16.5.e.i.2; Eight medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the two wings (currently the hospital and rest home are combined). Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Regular weekly controlled drug checks have occurred. Registered nurses or senior caregivers administer medications who have passed their competency administer medications.</p> <p>The service uses four weekly robotic packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines.</p>
<p>Finding:</p> <p>i)Three of eight medication charts sampled have PRN medications documented that do not include indications for use. (ii) Three of eight medication charts sampled have instances where regular medications have not been signed as administered.</p>
<p>Corrective Action:</p> <p>i)Ensure all PRN medication prescriptions include indications for use. (ii) Ensure medications are administered as prescribed.</p>
<p>Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

The national menus have been audited and approved by an external dietitian.

The service employs one cook and one relieving cook. The main kitchen supplies meals for the hospital/rest home and the dementia unit. Improvements since the previous audit include the kitchenette in the hospital having been completed and a system having been developed including provision to make hot drinks in the dementia unit, that allows meals to be served hot from a trolley to the five current residents in the dementia unit.

The two cooks at Bupa Glengarry have completed food safety certs.

The service has a large workable kitchen that contains 1 walk-in pantry, freezer, a domestic fridge with snacks for dementia unit, walk in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. These are within safe limits and this is an improvement since the previous audit. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. A number of audits completed include; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit.

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The building holds a current warrant of fitness - expiry date 1 June 2014.

All wings and operational areas in the service are fully functional and the dementia unit is secure from the rest of the facility with a locked door and secure fencing. The external landscaping is completed in all areas including in the dementia unit. These are improvements since the previous audit.

The facility has a van available for transportation of residents - van audit completed June 2013 93% compliance. Those staff transporting residents hold a current first aid certificate. The service completes environmental audits and building compliance audits (last completed August 2013 98% compliance).

The maintenance programme ensures all buildings, plant and equipment are maintained to an appropriate standard or specification where a standard exists for example a planned maintenance system, reactive maintenance system, list of equipment requiring calibration and current calibration reports, list of external contractors and list of preferred suppliers.

In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. Consideration is given to residents when purchasing new furniture/equipment. Relevant persons are consulted when selecting furniture, equipment, floor surface coverings. A procurement manager assists with ensuring appropriate purchase of equipment e.g. hoists, air relief mattresses. There is outside areas that include shade around the facility.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities and there is a garden/path and grass area with outdoor furniture and a fountain at one end.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, two hoists (one standing and one sling), heel protectors, lifting belts. All equipment has been checked and calibrated on 30 October 2013.

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

E3.4.c; There is a safe and secure outside area that is easy to access with two exits into and out of the dementia unit.

The current nine bed dementia unit is to be divided into a four bed psychogeriatric unit and a five bed dementia unit. The two units are already divided by double doors which the facility manager states will be locked with a key pad. Access to the new psychogeriatric unit will be via the dementia unit.

The two units will share one shower in the dementia unit with residents from the psychogeriatric unit being accompanied by a staff member from that unit when showering and a further staff member remaining in the psychogeriatric unit.

Each of the two units has a small lounge and dining area and each has access to the garden which is separated by a lockable pool fencing gate and fence.

ARHSS, D15.3: There is one toilet in each unit and the two units will share a shower based in the dementia unit. Staff from the PG unit will individually accompany each resident when using the shower.

Residents in each unit have their own bedrooms should they require a quiet environment and each room is close to the lounge area.

Previous improvements required around separation of the dementia unit from the rest home/hospital, paths in the hospital area, dementia courtyard landscaping have been addressed.

Improvements are required to the separation of the psychogeriatric and dementia units, and to a code of compliance for the hospital/rest home wing.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low
Evidence: The current nine bed dementia unit is ready to be divided into a four bed psychogeriatric unit and a five bed dementia unit. The two units are already divided by double doors which the facility manager states will be locked with a key pad. The hospital wing is completed (verified 4 December 2012).
Finding: (i)The key pad is not yet on the doors separating the dementia and psychogeriatric units. ii) A Code of Compliance for the hospital/rest home wing has not yet been issued.
Corrective Action: (i)Ensure that the dementia unit and PG unit can be separate by a locked door. ii) Ensure that the hospital/rest home has a Code of Compliance.
Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: <p>Hot water temperatures are now monitored in all areas on a weekly basis. There are some recordings that indicate that there are a range of temperatures i.e. in the past three months from 39.6 deg C to 51 deg C. However there are corrective action plans to address each with evidence that these are addressed. Head office has also completed a review in conjunction with the plumber (18 November 2013 plumber contacted and turned down as soon as high temperatures were noted) and the issue of the changing temperatures is being assessed for a more permanent solution. Tempering valves are already in place and the plumber visits the service regularly. Records of review by the head office properties manager and maintenance staff are documented for September 2013. This included commissioning of the plumber to complete the report.</p> <p>The previous improvement required around hot water temperature recording has been addressed (previously 1.4.3.2).</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Appropriate training, information, and equipment for responding to emergencies is provided.</p> <p>All staff complete a fire drill six monthly - last completed August 2013 for the rest home and a full evacuation has been completed in September 2013 for all areas including the hospital, rest home and dementia unit.</p> <p>Smoke alarms, sprinkler system and exit signs are in place and staff can describe training around these.</p> <p>The fire evacuation plan is sighted - date of approval 21 May 2012. The amended fire plan was sent to Wairoa New Zealand Fire Service following the completion of the reconfiguration of the service to include a secure dementia unit. The facility manager state that confirmation has been given by the New Zealand Fire Service that an amended evacuation plan is not necessary as structural changes have not been made.</p> <p>One staff in the rest home/hospital and one in the dementia unit on afternoons and night shift carries a pendant that connects to a call centre which is tasked with ringing back to check that it is an emergency call. If there is no answer, then they call the police immediately.</p> <p>The call bells in the hospital/rest home are fully operational as are the call bells in the dementia unit and all staff on duty carry a pager.</p> <p>There is one staff member in the dementia unit at any given time and there are emergency buttons in each room that can connect to the rest home/hospital area. The caregiver states that if the button is pushed, then staff come immediately.</p> <p>An audit completed in October 2013 indicates that 81% of staff are aware of emergency responses. A corrective action plan is being implemented by the facility manager. Improvements required to the following have been addressed: fire drills and call bells.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

Where required by legislation there is an approved evacuation plan.

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

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:

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

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

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service remains restraint and enabler free since June 2013. They have had limited restraint use over the last year.

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

The policy around restraint and enablers is applicable to the type and size of the service (rest home, hospital and dementia unit). Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, including definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option. There are two enablers (bedrails) in use and no restraints. Two files with enablers were reviewed and included consents, an assessment and linked to the care plan.

E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. Staff have had training around challenging behaviours, restraint and enablers at Glengarry Rest Home and Hospital last in July 2013.

Three caregivers interviewed (two hospital / rest home and one dementia unit); the facility manager and the registered nurse interviewed confirm knowledge of restraint, enablers and management of challenging behaviours.

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): <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 3.5: 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: <p>The infection control surveillance policy describes the surveillance programme. The infection control committee meets two monthly. Previously the infection control meeting was part of the health and safety but has now been separated out (meeting minutes sighted in June, September, October, and November 2013). There is a national infection control meeting via teleconference at least annually.</p> <p>A monthly infection summary report is completed with benchmarking against other Bupa facilities for dementia unit, rest home and hospital.</p> <p>The infection control data is in the dementia unit office and the office in the rest home/hospital for staff to review. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.</p> <p>The infection control coordinator is the facility manager (registered nurse). Infection control data is also discussed at staff meetings when issues arise. The minutes are also tabled at the quality meeting. Internal audits are completed in 2013 as per schedule e.g. standard precautions July 2013 – 96.8% compliance, laundry June 2013 – 95% compliance, kitchen environment/hygiene/food safety October 2013 – 99% compliance.</p> <p>Staff interviewed including the three caregivers, facility manager and registered nurse confirm knowledge of best infection control practice and of surveillance data.</p>

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