

# Bupa Care Services NZ Limited - Eventhorpe Rest Home & Hospital

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Current Status: 12 March 2014

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

## General overview

Eventhorpe Rest Home and Hospital is part of Bupa Care Services Limited (Bupa) The service provides hospital and rest home level care for up to 89 residents. On the day of audit, there were 83 residents – 34 at rest home level care and 49 at hospital level care.

This audit verified two new rest home rooms and three new hospital rooms as appropriate to provide the respective level of care and the service is able to cater for the extra five residents at these care levels.

Eventhorpe Rest Home and Hospital is managed by an overseas registered nurse who does not maintain a practicing certificate. She has been with Bupa for eight years and in care home roles for the last four years. She has been in this role since April 2013. She is supported by a clinical manager who is a registered nurse and has worked in aged care clinical and management roles since 1985. She has been at the service for 18 months. The Bupa regional manager (RN) also supports the manager. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place, staff turnover remains low. Family and residents interviewed spoke positively about the service provided.

Four of the seven shortfalls identified in the previous audit have been addressed. These are around review of staff incidents, incident reporting, wound documentation and aspects of medication management. Improvements continue to be required around aspects of the quality management system, corrective action planning and care plan interventions. This surveillance audit identified improvements required around staff orientation and 'as required' (PRN) medication prescribing.

## Audit Summary as at 12 March 2014

Standards have been assessed and summarised below:

### Key

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

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

#### Consumer Rights as at 12 March 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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#### Organisational Management as at 12 March 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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#### Continuum of Service Delivery as at 12 March 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### **Safe and Appropriate Environment as at 12 March 2014**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### **Restraint Minimisation and Safe Practice as at 12 March 2014**

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### **Infection Prevention and Control as at 12 March 2014**

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Bupa Care Services NZ Limited
<b>Certificate name:</b>	Bupa Care Services NZ Limited - Eventhorpe Rest Home & Hospital
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Eventhorpe Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 12 March 2014 <b>End date:</b> 13 March 2014
<b>Proposed changes to current services (if any):</b>	
	The service has added two new rest home rooms and three new hospital rooms.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	83

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	6
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	1

## Sample Totals

Total audit hours on site	24	Total audit hours off site	15	Total audit hours	39
Number of residents interviewed	10	Number of staff interviewed	25	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	83	Number of relatives interviewed	11
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Friday, 11 April 2014

## Executive Summary of Audit

### General Overview

Eventhorpe Rest Home and Hospital is part of the Bupa group. The service provides hospital and rest home level care for up to 89 residents. On the day of audit, there were 83 residents – 34 at rest home level care and 49 at hospital level care. This includes two new rest home rooms and three new hospital rooms that this audit has assessed as appropriate to provide the respective level of care from and the service is able to cater for the extra five residents at these care levels.

Eventhorpe Rest Home and Hospital is managed by an overseas registered nurse who does not maintain a practicing certificate. She has been with Bupa for eight years and in care home roles for the last four years. She has been in this role since April 2013. She is supported by a clinical manager who is a registered nurse and has worked in aged care since 1985 including in management roles. She has been at the service for 18 months. The Bupa regional manager (RN) also supports the manager. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place, staff turnover remains low. Family and residents interviewed spoke positively about the service provided. Four of the seven shortfalls identified in the previous audit have been addressed. These are around review of staff incidents, incident reporting, wound documentation and aspects of medication management. Improvements continue to be required around aspects of the quality management system, corrective action planning and care plan interventions. This surveillance audit identified improvements required around staff orientation and 'as required' (PRN) medication prescribing.

### Outcome 1.1: Consumer Rights

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

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

### Outcome 1.2: Organisational Management

Eventhorpe Rest Home and Hospital has an established quality and risk management system. There are improvements required around the quality system. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Eventhorpe Rest Home and Hospital is benchmarked in two of these (hospital and rest home). The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an improvement required around orientation

documentation. There is a comprehensive in-service training programme covering relevant aspects of care and support and the requirements. The organisational staffing policy 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.

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

The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, 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. Improvements are required in relation to wound care documentation. Improvements continue to be required in relation to documentation of interventions to meet assessed care needs.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. Improvements are required around the prescribing of as required medications.

The activities programme is facilitated by four activities assistants and a van driver. Residents and families report satisfaction with the activities programme. The programme includes significant community engagement including competitions with other aged care facilities in the area.

The cook cooks all food on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans.

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

Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. The building holds a current warrant of fitness. The service has added two new rest home rooms and three new hospital rooms. These are all large single rooms and well able to cater to the needs of the residents at the respective care levels. The lounges and dining areas and showering and toilet facilities are able to cater for the extra five residents. No change has been required to the approved evacuation scheme.

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

There are clear guidelines in policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has five residents using restraint and four residents using enablers. Training has been provided around restraint, enablers and challenging behaviours.

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

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and

infections, which have been completed in 2013 as per internal audit schedule.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	12	0	2	2	0	0
<b>Criteria</b>	0	36	0	3	2	0	0

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

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	(i)At Eventhorpe, there is a falls focus group that meets monthly. While the various committees are meeting and recording actions it was noted that the falls focus group discuss number and type of falls, however there is inconsistent evidence of reporting from these	(i)Ensure that outcomes of various meetings are reported to staff when they are required to act on this. (ii) Ensure staff holding quality portfolios attend quality meetings. (iii) Ensure quality data reported is consistent across all reports. (iv) Ensure quality data is analysed for trends and that these are discussed at the	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>meetings through to the quality improvement meeting or staff meeting so staff can implement corrective actions, (ii) staff holding quality portfolios do not appear on the quality improvement meeting minutes - eg. Infection and restraint coordinators, (iii) incident data is reported through to the various meetings as well as to head office. Review of incident did not consistently reconcile, thus making it difficult to determine actual volumes - eg. There were eight current pressure areas at the end of February 2014 but reporting to head office stated five for this period, (iv) Quality data are reported for infection control, health and safety and quality meetings. However, there is no evidence of trend analysis or discussion regarding trends.</p>	<p>appropriate meetings.</p>	
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective action plans are not developed when the service is above the accepted Bupa benchmark. For example the rest home	Ensure corrective action plans are developed and implemented when service shortfalls are identified.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>was above the benchmark for skin tear in November and December 2013 and January 2014 and for bruising in October, November and December 2013 and January 2014 and the hospital was above the benchmark for skin tears in October, November and December 2013 and January 2014 with no corrective action plans or quality improvement plans developed to address these areas.</p>		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	<p>Three of six staff files sampled do not have a completed orientation appropriate to the role. It is noted that one of these files was for a staff member who commenced employment as a caregiver and completed an orientation for this role but did not complete a registered nurse orientation when he became a registered nurse. Following the audit the service has</p>	Ensure all staff complete an orientation appropriate to their role.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				advised that all staff files have been reviewed and any existing staff who did not have a documented orientation on their file have retrospectively completed one.		
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	One hospital resident file (link 1.3.3) notes a weight loss of 6.8 kgs since January 2014. (i) There is no short-term care plan in place around weight loss. (ii) The last weight documented was 3 March 2014 and the resident is not to be seen by the GP until 18 March 2013. The GP requested a dipstick of the resident's urine on 14 February 2014 and no evidence of this could be found. (iii) The progress notes and nutritional assessment identify the need for a soft diet, this was not transferred to the long-term care plan. The resident was using a restraint but no restraint care plan was documented. (iv)The behaviour-monitoring chart commenced on the	(i)Ensure all short-term needs are addressed in short-term care plans. (ii) Ensure residents with weight loss are seen promptly by GP's and that GP's instructions are implemented. (iii) Ensure all identified needs are addressed in the care plan. (iv) Ensure all assessments are reviewed by a registered nurse. (v) Ensure all residents have an initial care plan developed within 24 hours of admission.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				17 January 2014 had no evidence of a review. (v) The hospital respite care resident had no support care plan developed for 16 days after admission.		
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 Low			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Five of twelve medication charts sampled have prn medications prescribed with no indications for use documented. The pharmacy generated medication charts often indicate a generic indication for use that is not specific to the resident. An example 'clonazepam that documents being for epilepsy when the resident does not have epilepsy'.	Ensure medications charted have indications for use documented, which are specific for that for that resident.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

#### Evidence:

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

Three registered nurses (two from the hospital and one from the rest home) and the clinical manager interviewed stated that they record contact with family/whanau on the family/whanau contact record (sighted). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident.

Incident forms sampled from February 2014 identified on 14 of 14 incident forms that family were informed. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in April 2013 at Eventhorpe Rest Home and Hospital with a result of 95.6%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b The 11 relatives (four from the rest home and seven from the hospital) interviewed stated that they are always informed when their family members health status changes.

The interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and government agencies is available. In addition, a number of staff is able to assist with interpreting for care delivery. A policy on contact with media is also available.

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

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

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The number of complaints received each month is reported monthly to head office via the facility benchmarking spreadsheet'. There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and prominent around the facility on noticeboards. A complaints register is up to date and includes relevant information regarding the complaint (there have been 11 complaints in 2013 and two in 2014 to date). Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are encouraged and actions and response are documented. Discussion with 11 relatives confirmed they were provided with information on complaints and complaints forms are available at the entrance. Four relatives described having concerns addressed immediately when brought up with management. Of the two complaints in 2014, one has involved the DHB. This was around a family's perception that a resident had experienced increased falls and was found not to be substantiated. The DHB have written to the family informing them of the outcome of the complaint.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Eventhorpe Rest Home and Hospital is part of the Bupa group. The service provides hospital and rest home level care for up to 89 residents. On the day of audit, there were 83 residents – 34 at rest home level care and 49 at hospital level care. This includes two new rest home rooms and three new hospital rooms that this audit has assessed as appropriate to provide the respective level of care and the service is able to cater for the extra five residents at these care levels.</p> <p>Eventhorpe Rest Home and Hospital is managed by an overseas registered nurse who does not maintain a practicing certificate. She has been with Bupa for eight years and in care home roles for the last five years. She has been in this role since April 2013. She is supported by a clinical manager who is a registered nurse and has worked in aged care since 1985 including in management roles. She has been at the service for 18 months. The Bupa regional manager (RN) also supports the manager.</p> <p>Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, Eventhorpe Rest Home and Hospital has developed an annual quality plan. Eventhorpe has set specific quality goals for 2014. Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.</p> <p>There is an overall Bupa business plan and risk management plan.</p> <p>Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider is completed by Bupa for Eventhorpe Rest Home and Hospital (link 1.2.3.8).</p> <p>Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes are implemented at all sites including</p>

Eventhorpe Rest Home and Hospital. Bupa has robust quality and risk management systems implemented at Eventhorpe Rest Home and Hospital. Internal audits are completed and all quality data and initiatives and data discussed at facility meetings (minutes sighted). Specific issues identified in Health & Disability Commission (HDC) reports (learning's from other provider complaints) are also tabled at this forum. The aim is to review the past and looking forward. Specific issues identified in Health & Disability Commission (HDC) reports (learning's from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly.

The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager care homes. The Eventhorpe Rest Home and Hospital manager meets with other Bupa managers in the regional teleconference weekly, Quarterly quality reports on progress towards meeting the quality goals identified are completed at Eventhorpe Rest Home and Hospital and forwarded to the Bupa quality and risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Eventhorpe Rest Home and Hospital continues to implement the "personal best" initiative whereby staff is encouraged to enhance the lives of residents.

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. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

**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.

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

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

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

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

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Eventhorpe Rest Home and Hospital has a quality and risk management system. Quality and risk performance is reported across the facility meetings, through the communication book, on the noticeboard and to the organisation's management team.

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

Key components of the quality management system link to the quarterly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected and staff incidents/accidents; b) The service has linked the complaints process with its quality management system; c) There is a monthly infection control (IC) committee at Eventhorpe Rest Home and Hospital. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. d) Health and safety committee meets monthly and is an agenda item at the quality committee. However, staff holding quality portfolios such as infection control and restraint do not regularly attend the quality meetings. This is a previously identified shortfall that continues to require improvement. Health and safety and incident/accidents, internal audits are completed. Quality data are reported for infection control, health and safety and quality meetings. However, there is no evidence of trend analysis or discussion regarding trends. Quality data including infection rates and accidents/incidents are presented at quality meetings. However, there is no trend analysis or discussion of the results of data analysis. This is an area requiring improvement. Staff and resident health & safety incidents are forwarded to Bupa health and safety coordinator. Any serious incident at any facility is reported to all Bupa facilities as memos/warnings. Annual analysis of results is completed and provided across the organisation. Staff incidents are

discussed at health and safety meetings and the facility manager and clinical manger both attend these meetings. These are improvements since the previous audit. e) The facility restraint meeting meets monthly and the Bupa regional restraint approval group meets six monthly. At Eventhorpe, there is a falls focus group that meets monthly. While the various committees are meeting and recording actions the following was noted that the falls focus group discuss number and type of falls, however there is inconsistent evidence of reporting from these meetings through to the quality improvement meeting or staff meeting so staff can implement corrective actions, Incident data is reported through to the various meetings as well as to head office. Review of incidents did not consistently reconcile, thus making it difficult to determine actual volumes - eg. There were eight current pressure areas at the end of February 2014 but reporting to head office stated five for this period. These are previously identified shortfalls that continue to require addressing.

There is an implemented internal audit programme. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Eventhorpe Rest Home and Hospital via graphs and benchmarking reports.

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the operations managers region is also provided for the operations manager, which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / health & safety staff indicators etc. throughout the year. (Operations manager’s monthly summaries).

D19.3: There is a comprehensive health & safety and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a health & safety coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2013 with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury (these have continued over from 2012). On-going review of these objectives for Eventhorpe Rest Home and Hospital is documented in health & safety meeting minutes.

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

**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.

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

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

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

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

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

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

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

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

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

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

**Criterion 1.2.3.6 (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.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Bupa Eventhorpe is active in collecting data and corrective actions are required based on benchmarking outcomes with reporting by the facility manager to the operations manager weekly, and then monthly to the GM. At Eventhorpe the monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, health and safety, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and corrective action plans are completed where a noncompliance is identified.
<b>Finding:</b> (i)At Eventhorpe, there is a falls focus group that meets monthly. While the various committees are meeting and recording actions it was noted that the falls focus group discuss number and type of falls, however there is inconsistent evidence of reporting from these meetings through to the quality improvement meeting or staff meeting so staff can implement corrective actions, (ii) staff holding quality portfolios do not appear on the quality improvement meeting minutes - eg. Infection and restraint coordinators, (iii) incident data is reported through to the various meetings as well as to head office. Review of incident did not consistently reconcile, thus making it difficult to determine actual volumes - eg. There were eight current pressure areas at the end of February 2014 but reporting to head office stated five for this period, (iv) Quality data are reported for infection control, health and safety and quality meetings. However, there is no evidence of trend analysis or discussion regarding trends.
<b>Corrective Action:</b> (i)Ensure that outcomes of various meetings are reported to staff when they are required to act on this. (ii) Ensure staff holding quality portfolios attend quality meetings. (iii) Ensure quality data reported is consistent across all reports. (iv) Ensure quality data is analysed for trends and that these are discussed at the appropriate meetings.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Criterion 1.2.3.8 (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Corrective action plans are completed when an audit has an outcome below 95% or if an action is identified as being required. All corrective action plans sighted have evidence of having been implemented and the corrective action plan has been signed off. This is an improvement since the previous audit. One corrective action plan was developed relating to a medication error.
<b>Finding:</b> Corrective action plans are not developed when the service is above the accepted Bupa benchmark. For example the rest home was above the benchmark for skin tear in November and December 2013 and January 2014 and for bruising in October, November and December 2013 and January 2014 and the hospital was above the benchmark for skin tears in October, November and December 2013 and January 2014 with no corrective action plans or quality improvement plans developed to address these areas.
<b>Corrective Action:</b> Ensure corrective action plans are developed and implemented when service shortfalls are identified.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

### **Standard 1.2.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>D19.3c: The service collects incident and accident data. The category one incidents policy (044) includes responsibilities for reporting category (CAT) one incidents. The completed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)".</p> <p>D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. This is an improvement since the previous audit.</p> <p>The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&amp;S meeting do not reflect a discussion of trends and results (link 1.2.3.6).</p> <p>Fourteen incident forms reviewed for February 2014 identified that all demonstrated clinical follow up by a registered nurse and monitoring (such as neuro obs) having been undertaken when indicated.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. The norovirus outbreak in December 2013 was notified to the appropriate authorities.</p>

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** PA Low

### Evidence:

A register of registered nurse and enrolled nurse practising certificates is maintained at facility level. Within Bupa, website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / links). There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven files reviewed files (one registered nurse, the cook, three caregivers and an activity coordinator) and all had up to date performance appraisals. All staff files included a personal file checklist. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, registered nurse four weeks); during this period, they do not carry a clinical load. Completed orientation booklets are on staff files in four of seven staff files sampled. It is noted that one of these files was for a staff member who commenced employment as a caregiver and completed an orientation for this role but did not complete a registered nurse orientation when he became a registered nurse. This is an area requiring improvement. Interviews with the clinical manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with core competencies level three unit standards. (These align with Bupa policy and procedures).

There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care - eg. Dementia, delirium and care planning. There is evidence on registered nurse staff files of attendance at the registered nurse training day/s and external training.

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

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

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

### 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:

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, registered nurse four weeks); during this period, they do not carry a clinical load. Completed orientation booklets are on staff files in three of six staff files sampled.
<b>Finding:</b> Three of six staff files sampled do not have a completed orientation appropriate to the role. It is noted that one of these files was for a staff member who commenced employment as a caregiver and completed an orientation for this role but did not completed a registered nurse orientation when he became a registered nurse. Following the audit the service has advised that all staff files have been reviewed and any existing staff who did not have a documented orientation on their file have retrospectively

completed one.

**Corrective Action:**

Ensure all staff complete an orientation appropriate to their role.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

The roster is flexible to allow for the increase of numbers of residents.

There is one RN at the facility between 9 pm and 7 am and two between 7 am and 9 pm, plus the clinical manager five days a week.

Interviews with 15 caregivers (across morning and afternoon shift) confirmed that staffing numbers were satisfactory most of the time. Interviews with ten residents (six rest home and four hospital) and 11 relatives (seven hospital and four rest home) had no concerns about staffing levels.

The current staffing levels are sufficient to meet the needs of the additional two rest home residents and three hospital residents that this audit has assessed to services ability to cater for.

### 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.

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

## Outcome 1.3: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The initial assessments and support plans were completed by the registered nurse in five of six files sampled within three weeks of admission (two hospital, three rest home). One of six files (hospital respite) had evidence the initial assessments were completed but no support plan documented sixteen days after admission (link 1.3.6.1). This documentation was completed and signed off by a registered nurse on day of audit.</p> <p>Five of five long term care plans sampled (two hospital, three rest home) identified that the initial admission assessments, care plan summary and long term care plans were completed by registered nurses. A range of assessment tools were used 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.</p> <p>D16.2, 3, 4: The five long term files sampled (two hospital, three rest home ), evidenced that the care plan is reviewed by a registered nurse and amended when current health changes. All five long-term resident care plans (two hospital, three rest home) evidenced evaluations completed at least six monthly. Medical assessments are completed on admission by the general practitioner (GP) in five of five long term resident files sampled and six monthly multi-disciplinary reviews are completed by the</p>

registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person. The respite resident file included a letter from the GP, detailing recent events and medication currently being taken. Ten residents interviewed (four hospital and six 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 the five long term resident files sampled.

D16.5e: All five long-term resident files reviewed (two hospital, three rest home), identified that the GP had seen the resident within two working days of admission. It was noted in the five long term resident files (two hospital, three rest home), the GP had assessed the resident and documented the frequency for review to be between one to three monthly.

In all five long term resident files (two hospital, three rest home), physiotherapy assessments, management plans and transfer plans are completed by physiotherapist. The activities team interviewed confirmed that they complete 'the day in a life of' and activities section of the care plans.

The residents (four hospital, six rest home) and families (four rest home, seven hospital) interviewed all stated they felt their care needs were being met.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Five of five long term resident files identified integration of allied health and a team approach.

The GP interviewed spoke positively about the service and describes very effective communication processes.

Tracer methodology – rest home.

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

Tracer methodology – hospital:

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

### Evidence:

The care being provided is consistent with the needs of the resident as evidenced through interview with residents, families and staff.

Residents' care plans are completed by registered nurse. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes (three hospital and three rest home). When a resident's health status changes, the registered nurse initiates a review and if required arranges general practitioner or specialist consultation. The families interviewed confirmed they are informed if there has been a change in health status.

Four of six files sampled contain appropriately documented care plans that include interventions for all identified areas of need (two hospital and two rest home). The hospital patient (link 1.3.3) notes a weight loss of 6.8 kgs since January 2014. There is no short term care plan in place around weight loss. The last weight documented was 3 March 2014 and the resident is not to be seen by the GP until 18 March 2013. The progress notes and nutritional assessment identify the need for a soft diet, this was not transferred to the long term care plan. The resident was using a restraint but no restraint care plan was documented. The behaviour monitoring chart commenced on the 17 January 2014 had no evidence of a review. The GP requested a dipstick of the resident's urine on 14 February 2014 and no documented evidence of this could be found. These are areas requiring improvement.

One hospital respite care resident had no support care plan developed for 16 days after admission. This was completed on day of audit and is a further area requiring improvement.

The fifteen caregivers interviewed (four rest home and eleven 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 spoken to confirm that when equipment is needed it is provided promptly. Staff spoken to all report access to educations for specialist care services. Staff report that there is sufficient stocks of continence products. On tour of the facility, it was sighted that stock continence and dressing supplies were available for use.

Ten of ten of residents interviewed (six in the rest home and four in the hospital) were able to verbalise on interview that they feel well cared for. Eleven family members interviewed (four rest home, seven hospital) are very positive about the care that residents receive.

Wound assessment and wound management plans are in place for 18 residents in the hospital and 23 in the rest home. There are corresponding short-term care plans evident for wounds and these are filed in the resident files. There are wound management plans in place for 10 pressure areas (all hospital). This is an improvement since the previous audit. (Link to 1.2.3.6 relating to under reporting of pressure areas).

During the tour of facility, it was noted that all staff treated residents with respect and dignity, which was confirmed by the residents and families.

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

### 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.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The care being provided is consistent with the needs of the resident as evidenced through interview with residents, families and staff.  Residents' care plans are completed by registered nurse .Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes (three hospital and three rest home). When a resident's health status changes, the registered nurse initiates a review and if required arranges general practitioner or specialist consultation. The families interviewed confirmed they are informed if there has been a change in health status.
<b>Finding:</b> The hospital patient notes a weight loss of 6.8 kgs since January 2014. (i) There is no short-term care plan in place around weight loss. (ii) The last weight documented was 3 March 2014 and the resident is not to be seen by the GP until 18 March 2013. The GP requested a dipstick of the resident's urine on 14 February 2014 and no evidence of this could be found. (iii) The progress notes and nutritional assessment identify the need for a soft diet, this was not transferred to the long-term care plan. The resident was using a restraint but no restraint care plan was documented. (iv)The behaviour-monitoring chart commenced on the 17 January 2014 had no evidence of a review. (v) The hospital respite care resident had no support care plan developed for 16 days after admission.
<b>Corrective Action:</b> (i)Ensure all short-term needs are addressed in short-term care plans. (ii) Ensure residents with weight loss are seen promptly by GP's and that GP's instructions are implemented. (iii) Ensure all identified needs are addressed in the care plan. (iv) Ensure all assessments are reviewed by a registered nurse. (v) Ensure all residents have an initial care plan developed within 24 hours of admission.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are four activities assistants and a van driver who work a combined total of 80 hours per week in the hospital and rest home areas. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. There are programmes running that are meaningful and reflect ordinary patterns of life. There is evidence of the wider community involvement with up to four outings per week to local places of interest, visits to the local library, weekly church services, inter - rest home bowls competitions, and pre -school groups visiting twice a year. In addition to the four outings per week, residents are offered the opportunity to go shopping weekly. Each Friday a happy hour is held with guest entertainers. The programme is developed monthly and displayed in large print. Residents are given opportunity to feedback on the programme verbally. Residents spoken to report satisfaction with the activities programme.

Residents have an assessment completed within the first three weeks of admission where information is obtained which includes a complete history of past and present interests, career, family etc. and information from this is fed into the lifestyle plan. A record is kept of individual residents activities. There are recreational progress notes in the resident's file that the activity staff complete 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.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.4a: Care plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur as sighted in five of five long term files sampled (two from the hospital, three from the rest home). There is at least a one to three monthly review by the medical practitioner. There are short-term care plans to focus on acute and short-term issues (link 1.3.6.1). Changes to the long-term care plan are made as required and at the six monthly reviews if required. Four of the five long-term files sampled (two from the hospital, three from the rest home) indicate that short-term care plans are well used and comprehensive. Examples of STCPs in use included (but not limited to); infections, wounds, behaviours that challenge and pain

**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.

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

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

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

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

### Standard 1.3.12: 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 Low

**Evidence:**

The service uses robotic sachet medications that are delivered two weekly. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication treatment rooms/cupboards were checked in all three clinical areas.

Two medication rounds were observed. The registered nurse administering the medication observed the correct procedures and checks. The medications are stored in locked trolleys in each clinical area. Controlled drugs are stored in a locked safe in the hospital treatment room and only the registered nurses have access to controlled drugs and two people (one being an RN) must sign controlled drugs out. The controlled drug register is well kept and aligns with legislative requirements. Weekly controlled drug checks are completed by the registered nurses. The shortfalls around medication management identified in the previous audit have been addressed.

There is currently one resident self-administering in the hospital area. The resident has been assessed as being safe to self-administer medication and it is noted in the care plan that the resident is self-medicating. The registered nurse checks that the medication has been taken as charted and notes this on the signing sheet. The medication is secured in a locked cupboard.

D19.2 d Medication is managed safely and appropriately in line within accepted guidelines. Twelve medication charts were sampled (six hospital and six rest home). All medication charts reviewed identified that the GP had seen the resident and reviewed the medication chart three monthly and all medication had been signed for. Medication profiles are computer generated and are legible, up to date and reviewed at least three monthly by the GP. Eye drops in use and dated and this is an improvement since previous audit. The medication chart has alert stickers for crushed, allergies, and duplicate name. Medication charts have photo ID's. Improvements are required around documenting indications for use for as required medication. Residents/relatives interviewed stated they are kept informed of any changes to medications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**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:** PA Low

**Evidence:**

D19.2 d Medication is managed safely and appropriately in line within accepted guidelines. Twelve medication charts were sampled (six hospital and six rest home). All medication charts reviewed identified that the GP had seen the resident and reviewed the medication chart three monthly and all medication had been signed for. Medication profiles are computer generated and are legible, up to date and reviewed at least three monthly by the GP.

**Finding:**

Five of twelve medication charts sampled have prn medications prescribed with no indications for use documented. The pharmacy generated medication charts often indicate a generic indication for use that is not specific to the resident. An example 'clonazepam that documents being for epilepsy when the resident does not have epilepsy'.

**Corrective Action:**

Ensure medications charted have indications for use documented, which are specific for that for that resident.

**Timeframe (days):** 90 (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 six kitchen staff including two cooks. The main kitchen supplies meals for the hospital and rest home.

All of the staff on the kitchen team at Eventhorpe Rest Home and Hospital have completed food safety certs. The kitchen manager at Eventhorpe Rest Home and Hospital takes part in a monthly teleconference with all other kitchen managers from Bupa and attends the Bupa kitchen manager's conference annually.

The service has a large workable kitchen that contains a walk-in pantry, freezer, walk in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates.

There is a preparation area and receiving area.

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

The kitchen 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, vegetarian and diabetics.

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

Daily temperature checks of chiller, freezers, bain marie and dishwasher are maintained.

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

The kitchen is well able to cater for the extra two rest home level residents and three hospital level residents that this audit has assessed the service as able to cater for.

### **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.

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

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

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

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

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

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

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

**Outcome 1.4: Safe and Appropriate Environment**

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

**Standard 1.4.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>The building holds a current building warrant of fitness that expires on 1 December 2014. Fire protection inspection services are responsible for the maintenance of fire equipment.</p> <p>There is a maintenance officer Monday to Friday and available on call for urgent matters. There are planned maintenance schedules for monthly (wheelchairs, nurse call system, and external lights), two monthly (air filters, air conditioners), three monthly (sanitizers), six monthly (trolleys) and annual (external) maintenance checks. Hot water temperature monitoring is conducted weekly. Weekly monitoring forms sighted. Electrical equipment is checked annually. BV medical calibrated all medical equipment and the sling hoists, electric beds and weighing scales were checked and serviced at this time.</p> <p>The corridors are spacious and there are handrails. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The furnishing and fixtures are appropriate to the consumer room. Seating is arranged to allow group and individual activities to occur.</p> <p>The external areas are well maintained and gardens are attractive. There is easy access to secure and safe walking paths from each external door. Outdoor seating and shade is available. There is wheelchair access to all areas.</p> <p>This audit has assessed two new rest home rooms and three new hospital rooms as suitable to meet the needs of these residents. The five new rooms are all large and</p>

have plenty of room to cater for residents, their mobility aids and caregivers. All these rooms have ceiling heaters and external windows. The lounges and dining rooms are large enough to cater for the extra residents and there are sufficient bathing and toileting facilities to cater for the extra five residents.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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.

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> 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 has four bedrails in use as enablers. There are five residents using restraint (four low beds, one bedrail and four t/belts). The two files reviewed of the residents with an enabler included assessment, consent,

interventions and three monthly evaluations.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings (link 1.2.3.6). The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with

the quality management programme. The results are subsequently included in the manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP who advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

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

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

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

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

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

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