# Bupa Care Services NZ Limited - BeachHaven Hospital

## Current Status: 25 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

BeachHaven is part of the Bupa group of facilities and provides care for up to 99 hospital - geriatric/medical and psychogeriatric care across three units. The East unit has hospital residents, Tui units include psychogeriatric (PG) residents and Kowhai is a secure hospital unit.

BeachHaven continues to implement a comprehensive quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms demonstrate a culture of quality improvements and this continues to be maintained since previous audit.

There is a stable management and staff team that support a consistent approach. The facility manager and clinical manager are experienced aged care managers.

The three shortfalls identified at the previous audit around staffing, information provided to families and medication documentation has been addressed. This surveillance audit identified one improvement required around follow through of a GP instruction.

## Audit Summary as at 25 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 |
|  | 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 25 March 2014

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

### Organisational Management as at 25 March 2014

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| 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 25 March 2014

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| 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 low risk. |

### Safe and Appropriate Environment as at 25 March 2014

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

### Restraint Minimisation and Safe Practice as at 25 March 2014

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

### Infection Prevention and Control as at 25 March 2014

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| 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. |

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **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**

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| --- | --- |
| **Legal entity name:** | Bupa Care Services NZ Limited |
| **Certificate name:** | Bupa Care Services NZ Limited - BeachHaven Hospital |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | BeachHaven Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (incl. psychogeriatric); Residential disability services - Intellectual; Residential disability services - Physical | | | |
| **Dates of audit:** | **Start date:** | 25 March 2014 | **End date:** | 26 March 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 99 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 14 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 14 | **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**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 28 | Total audit hours off site | 10 | Total audit hours | 38 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 1 | Number of staff interviewed | 17 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 109 | Number of relatives interviewed | 7 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, 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:

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| --- | --- | --- |
| 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 Tuesday, 6 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| BeachHaven is part of the Bupa group of facilities and provides care for up to 99 hospital - geriatric/medical and psychogeriatric care across three units. The East unit includes 27 of 27 hospital residents. Tui unit includes 32 of 32 psychogeriatric (PG) residents (this is divided in to two separate unit’s 16-bed men’s wing and a 16-bed female wing. Kowhai is a secure hospital unit. The Kowhai unit includes 40 of 40 residents (32 assessed hospital level and eight assessed psychogeriatric).  BeachHaven continues to implement a comprehensive quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms demonstrate a culture of quality improvements and this continues to be maintained since previous audit.  There is a stable management and staff team that support a consistent approach. The facility manager and clinical manager are experienced aged care managers.  The three shortfalls identified at the previous audit around staffing, information provided to families and medication documentation has been addressed. This surveillance audit identified one improvement required around follow through of a GP instruction. |

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| **Outcome 1.1: Consumer Rights** |
| Residents and relatives are kept well informed at an organisational and facility level. Relatives interviewed confirmed they were well informed of incidents/accidents and changes of health status. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed. |

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| **Outcome 1.2: Organisational Management** |
| BeachHaven has an established quality and risk management system that supports the provision of clinical care and support. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. BeachHaven is benchmarked in two of these (psychogeriatric and hospital). 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. Corrective action plans are established when incidents are above the benchmark. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and the requirements. All caregivers working in the PG unit have completed or are in the process of completing the required dementia standards. The organisational staffing policy aligns with contractual requirements and includes skill mixes. The Bupa wage analysis schedule (WAS) is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the long-term support plan to guide staff in the safe delivery of care to residents. The care plans are goal oriented and reviewed every six months with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. Information regarding the keypads entry and exits are now included in the BeachHaven booklet. This is an improvement from the previous audit. An improvement is required around one resident file to ensure it evidences follow through from a GP instruction.  The diversional therapist and two-activity assistant’s co-ordinate separate programmes in the three units that meets the individual needs, preferences and abilities of the residents.  Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency test and receive annual education. The previous medication management shortfalls have been addressed.  Residents' food preferences are identified at admission. This includes consideration of any particular dietary preferences or needs (including cultural needs). Additional nutritious snacks and “finger foods” are available in the units. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has a current Building Warrant of Fitness and approved evacuation scheme. There is a 52-week maintenance programme in place. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint policy is in place. 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 service has 18 residents with bedrails on the restraint register and five residents in the hospital under environmental restraint due to the potential to abscond. There are no residents identified as requiring enablers. Training has been provided around restraint, enablers and challenging behaviours. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, regional restraint meetings and at an organisational level.  Any restraint incidents including emergency restraint are discussed in the monthly restraint meetings. Environmental restraint is reviewed informally for each of the five residents monthly and formally three monthly |

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| **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 as per the internal audit schedule.  Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 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 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | One of three hospital resident files sampled did not have blood sugar monitoring for a period of one week as instructed by the GP. | Ensure GP instructions and monitoring requirements are carried out. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **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. The three unit coordinators and three registered nurses interviewed stated that they record contact with family/whanau on the family/whanau contact record (sited). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for February (21 of 22 across the service) identified that family were notified. 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 December 2013 with a result of 91%; corrections were fed back to staff. 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 seven relatives interviewed (four PG, two hospital) stated that they are always informed when their family members health status changes.   The Bupa communications manager keeps people informed and engaged about Bupa NZ’s strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed. Newsletters were evident around BeachHaven. Interpreter’s policy and a list of Language Lines and Government Agencies are available. In addition, there is a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available.   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.  ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to the secure unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident’s handbook providing practical information for residents and their families |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint summary record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to the Quality and Risk team via the facility benchmarking spreadsheet'. There is a complaints process flowchart.  D13.3h. a complaints procedure is provided to residents within the information pack at entry  ARHSS D13.3g: The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards.   There is a complaints register that is up to date and includes relevant information regarding the complaint. For 2104 YTD, there are three verbal complaints and four written complaints. One complaint was investigated by the DHB with an outcome that the complaint was ‘not substantiated’. One complaint about care was thoroughly actioned by the service and a corrective action plan was initiated and shared with the complainant and staff. 2013 complaint register was reviewed and included six written, and seven verbal complaints. All complaints reviewed evidenced that documentation including follow up letters and resolution. Discussion with seven relatives confirmed they were provided with information on complaints and complaints forms are available within the facility. |

##### **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.

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. At BeachHaven, quality goals involve all departments and each area takes ownership of their goals, progress, on-going reporting and evaluation. For 2014, there are 13 identified goals including (but not limited to); a) Activities department – to organise a theme month culminating in a theme day/week celebration; b) clinical team – to reduce medication errors by 75%; c) H&S team – To promote & support the wellbeing of staff, increasing GPS result to 55%+ (Healthier, Happier staff). D) Kitchen – To improve the experience of new resident’s family following admission. Progress to meeting those goals were reported monthly.  BeachHaven is part of the Bupa group of facilities and provides care for up to 99 hospital - geriatric/medical and psychogeriatric care across three units. The East unit includes 27 of 27 hospital residents. Tui unit includes 32 of 32 psychogeriatric residents (this is divided in to two separate units a 16-bed men’s wing and a 16-bed female wing. Kowhai is a secure hospital unit. The Kowhai unit includes 40 of 40 residents (32 assessed hospital level and eight assessed psychogeriatric). The DHB are aware of the secure hospital unit that includes a combination of hospital and PG residents. The manager advised that all residents within this unit have some form of dementia and behaviours that challenge and require a secure environment. Only one hospital resident within the facility was mentally-competent to be interviewed. There are no residents under the medical component of their certification. The service is also certified to provide residential disability – ID and PD level care. There are no residents under physical/intellectual disability contracts.   Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The organisation has a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly. Feedback is provided to each facility (sighted).  The service is managed by an experienced registered nurse that has been in the role for 27 years. The manager also has a certificate in gerontology. She is supported by a clinical manager whom has been in the role since for the last 13 years with over 30 years working at BeachHaven. The Clinical Manager attends the annual two day Clinical Manager’s Forum .She also attends the Link Nurse programme. Dementia Education held by DHB also Palliative Care Course held by Hospice. The management team is also supported by three unit coordinators (RNs). Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.  ARC, D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.  ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| BeachHaven continues to implement a comprehensive quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements and this continues to be maintained since previous audit. Key strengths identified of their quality system include (but not limited to); excellent involvement from staff in quality activities, b) evidence of ownership in quality & goal-setting by staff, c) good analysis of clinical stats at a unit level with involvement of staff in corrective action planning and evaluation. Quality and risk performance is reported across the facility meetings, through the communication book, staff noticeboard and also to the organisation's management team.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A Bupa policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the Quality and Risk Team. The clinical manager is a member of the policy consult group. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents.   Key components of the quality management system link to the two monthly quality committee. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation. The clinical manager provides two weekly newsletters to qualified staff and the facility manager monthly newsletters to all staff, which incorporate feedback on the quality activities/programme.  There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the hospital units, psychogeriatric units, and staff incidents/accidents. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. There is a two monthly infection control (IC) committee meeting. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee.   Health and safety committee meets two monthly and is also an agenda item at the quality committee. Health and safety (H&S) and incident/accidents, internal audits are completed. 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 memo's/warnings. Annual analysis of results is completed and provided across the organisation.    Monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided via graphs and benchmarking reports.   The facility continues to have two active committees that were implemented prior to the previous audit to manage key clinical risk areas. Due to the behaviour issues identified at BeachHaven, they are focussed on reducing the number of staff injured by the challenging behaviour of residents. A ‘Hit Squad’ continues to work as a team. They are able to monitor & mentor staff’ in the management of residents. A form is implemented to properly direct staff investigating the incident & identify the cause. Completed forms are discussed at the ‘Hit Squad’ meetings held two monthly. The 'people on the move team' has continued since 2011. The committee member’s review fall’s incidents and work with staff at floor level around manual handling. Notices and reminders from the 'people on the move' committee and the 'hit squad committee are evident. While the 2013 goals of reducing falls and reducing behaviour incidents to staff were not met, on-going strategies are discussed and initiated for 2014 and staff awareness and knowledge has increased.  A relative survey was last completed May 2013 with a 93% outcome. Corrective action plans were established around feedback on smell and security- belongings. This was shared with relatives and staff.  A quality committee pre goal setting meeting was held January 2014, which also evaluated the achievement of the 2013 goals, what was achieved and what areas were not met, and why.  There is a ‘resident focussed’ nurses forum and meets fortnightly to discuss and manage resident clinical risk and care.   A monthly summary of each facility within the Operations Managers region is also provided for the Operations Managers, which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Operations Managers monthly summaries).   Benchmarking reports are generated throughout the year to review performance over a 12-month period. The service continues to collect data to support the implementation of corrective action plans e.g.: action plan for management of medication incidents in the hospital July – Dec 13. Responsibilities for corrective actions are identified and on-going evaluation evident. As a result, a 2014 goal has been established around reducing medication errors by 75%.  Quality action forms are utilised at BeachHaven and document actions that have improved outcomes or efficiencies in the facility including (but not limited to); reducing risk of resident’s access to creams & ointments & loss of toiletries; using visual displays to reduce falls, computerised care planning, People on the Move awareness campaign, introduction of [pharmacy generated drug charts and “Back to Basics’ education session.  D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2014 with two objectives and BeachHaven have identified three goals for 2014.   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, sensor mats and perimeter mattresses. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The competed 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)". D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, unit, staff and H&S meeting reflect a discussion of results. Quality improvement corrective action plans were completed when incidents were above the benchmark.  Incident forms reviewed for February (22 of 22 across the service) demonstrated clinical assessment and follow up by a RN/clinical manager.  Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).  There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven files reviewed (two registered nurses, clinical manager, unit coordinator, two caregivers, activity therapist) all had up to date performance appraisals. All staff files included a personal file checklist.   The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, RN four weeks); during this period, they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (six caregivers, two registered nurse, two enrolled nurses, two unit coordinators) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.  Interviews with the staff educator confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (These align with Bupa policy and procedures).   There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. Training provided included at least four sessions monthly. Managing behaviours that challenge and Dementia were provided May and October 2013 (38 and 43 attended). There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. Dementia, Delirium. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training. Of the total number of caregivers, 47 of 50 have a qualification.  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. Toolbox talks held and staff been encouraged to participate.  A competency programme is in place with different requirements according to work type (e.g. caregiver, 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. Competency register was up to date at BeachHaven.  Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At BeachHaven, all registered nurses have completed or enrolled in the process of completing their portfolio on the Bupa Nursing Council approved PDRP. D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, Controlled Drug administration, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.  There are 46 caregivers that work across the psychogeriatric (PG) units. Thirtyfour have completed the required dementia standards, six are in process and five have not been with the facility longer than six months. One caregiver is being supported to complete numeracy and literacy to assist with completing  ARHSS D17.7: The activity therapists working across the PG unit have completed dementia training and one is a qualified diversional therapist. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The wage analysis schedule is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours. The service has made adjustments to the roster as an improvement on the previous audit around RN cover at night in the PG unit.  Across the two Kowhai wings (32 hospital /eight PG) there are two RNs rostered on the morning shift (plus six caregivers) and a unit coordinator (RN), two RNs on afternoon shift (and five caregivers) and one RN at night and (two caregivers).  In Tui Wings (32 PG) there is one RN across each shift and a unit coordinator (RN) in the morning. They are supported by a sufficient number of caregivers.  In East wing (27 hospital) there is a unit coordinator (RN), another RN or clinical assistant in the morning, an RN/EN afternoon shift and two caregivers at night. There are a sufficient numbers of caregivers and clinical assistants rostered.  Interviews with nine caregivers across all areas confirmed that staffing levels were good and that staff work well as a team. Interviews with seven relatives (four PG, two hospital) all stated that there was always staff around. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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 1.3.1: Entry To Services **(**HDS(C)S.2008:1.3.1)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service provides for hospital and psychogeriatric level of care. There are three separate units; East (27 hospital beds), Tui (two separate wings of 16 psychogeriatric beds each) and Kowhai a combined 40-bed unit psychogeriatric and hospital unit providing environmental restraint for identified residents only. The Bupa BeachHaven information booklet describes the keypad entry and exit to the Kowhai unit. This is an improvement from the previous audit. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D.16.2, 3, 4: The seven resident files sampled (three hospital and four psychogeriatric) identified that the registered nurses (RN) complete an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All seven files sampled identified that the long-term support plan is developed within three weeks. All seven long-term care plans sampled are signed and dated by the RN. Families confirmed on interview they are invited to attend the six monthly multidisciplinary care plan reviews and GP visits. The diversional therapist (DT) completes an activity assessment, “Map if Life” and individual activity care plan in consultation with the resident/family/whanau as appropriate. There is documented evidence (signature) of resident/family/whanau involvement in the care and activity plan process.  D16.5e: Seven of seven resident files sampled identified that the GP had seen the resident within two working days. It was noted in all resident files sampled that the GP has examined the resident monthly and carried out a three monthly medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. All seven resident files sampled identified integration of allied health professionals and a team approach.   There are two general practitioners who provide medical care to the residents. They visit twice a week each for routine reviews and there is a midweek visit to address any additional RN resident concerns and complete medical documentation required. The GP (interviewed) states the GP’s cover for each other patients and attend to residents of concern as required. The GP’s are available to meet with families. The GP is complimentary of the care provided to the residents and RN clinical assessments. All calls after hours are appropriate. The GPs are available 24/7 on mobile. The staff stability provides consistency of communication with the medical staff. Resident’s medical status is well known to the staff. Advance care planning is discussed with families. The GP has a close liaison with the geriatrician, psychogeriatrician and hospice team. The GPs are involved in six monthly multidisciplinary (MDT) reviews. The GP is actively involved in the reduction of psychotropic medications in consultation with the geronotology and psychogeriatric service. The service was involved in a DHB study on reduction of psychotropics and have continued with the practice that also involves the DHB pharmacist who reviews all medication charts monthly. The consultant pharmacist was present on the day of audit.   ARHSS D16.6; Four residents files sampled with behaviours that challenge have been reviewed from the mental health services for the older adult. There is evidence of psychogeriatrician correspondence and involvement in residents under psychogeriatric care. The support worker for mental health is readily available through the district health board (DHB). Behaviours in the four files are well identified through the assessment process. Specific needs and interventions (including activities) are detailed in the long-term care plan. Behaviour monitoring charts are in use (sighted). A dementia support group and field officer are available by phone and visits as required offering support to staff and families.   There is a verbal handover and written handover sheets at the beginning of each shift. The RN then provides a report on all residents to the caregiving team. There is a unit co-ordinator in each area. Nine caregivers (six hospital and three psychogeriatric) interviewed state the communication system is good and they receive relevant information at handover to deliver safe and timely cares for the residents.   A physiotherapist (physio) is contracted for four days a week. The physio is supported by a physio assistant who works four mornings a week and carries out physio instructions. The physio completes a transfer and mobility assessment on all new admissions. A physio diary is maintained and RNs enter referrals into the diary. The physio attends the six monthly MDT reviews and review residents post falls as required.   Tracer methodology;  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology;  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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Long-term care plans are goal oriented and reviewed six monthly for hospital and psychogeriatric residents. Risk tool assessments are completed on admission and include (but not limited to); nutritional assessment, continence assessment, falls risk, physio mobility and transfer assessment, pain assessment, pressure area risk, hygiene and skin assessment and cultural assessment, wound assessment , restraint assessment and behaviour assessment as applicable.   Nine caregivers and three RNs interviewed state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); electric beds, ultra-low beds, “noodles”, sensor mats, pressure area mattresses, hoists, wheel on scales, slidy sheets, transferring belts, walking frames, wheelchairs, gloves, masks and aprons. Relatives (two hospital, five psychogeriatric) interviewed confirm their relative’s needs are being met.   D18.3 and 4 Adequate dressing supplies are available. Wound management policies and procedures are in place. .  Wound assessment and wound management plans are in place for 11 skin tears and two sacral pressure areas in Kowhai unit; two skin tears, five minor wounds and one sacral ulcer in East unit, 11 skin tears and two minor leg wounds in Tui. All wounds are linked to the care plan. There is evidence of nurse practitioner referral and involvement in the healing process of one sacral ulcer. A pressure area identification guide is available with resources and turning charts in place for pressure area management.   Continence products are available, resident files include, and management a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. The three RNs interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse, dietitian, speech language therapist, ostomy nurse or other allied health or nursing specialists.   There are a number of monitoring forms in place that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, food and drinks list, blood sugar monitoring, bowel records, continence diary and neurological observations. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents' care plans are completed by the registered nurses. There is a short-term care plan that is used for acute or short-term changes in health status. STCPs were well utilised in seven of seven resident files reviewed. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. There are a number of monitoring forms in place that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, food and drinks list, blood sugar monitoring, bowel records, continence diary and neurological observations. |
| **Finding:** |
| One of three hospital resident files sampled did not have blood sugar monitoring for a period of one week as instructed by the GP. |
| **Corrective Action:** |
| Ensure GP instructions and monitoring requirements are carried out. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service employs a qualified diversional therapist (DT) (currently on leave) and two activity assistants who both work 6 hours a day Monday to Friday. Both activity assistants have completed the dementia course. One activity assistant is currently completing DT training. All the team attend on-site in services and attend the annual Bupa regional training day. The activity team meet monthly to plan the separate programmes for each unit. The team rotate between the three units and spend a month in each unit implementing the programme. The programme varies in each unit with group and individual activities and includes sensory activities. Activities include (but not limited to); art and craft, gardening, balloon games, beauty cares, floor games, sing-a-longs, inter-unit sport, table games, cooking, one on one massage, sit dance, one on one stories, movie and ice-creams, beer tasting, foot spas, outdoor walks and barbeques. Festive occasions are celebrated such a St Patricks day recently. There are weekly musical entertainers such as the ukulele group. Other community visitors are church groups monthly, Prescott club, pet therapy visits and volunteers visit twice weekly. The service has a 12-seated van with wheelchair access. The designated drivers have a current first aid certificate and there are regular outings for residents in each unit. Fortnightly on Sundays there is a van outing for residents with advanced cognitive impairment who enjoy going out for drives.  Activity resources are readily available for carers who take on activities roles within their units.   Resident (as appropriate) and family meetings and held. The activity team meet with the unit co-ordinators, clinical manager and facility manager monthly. All residents have an activity assessment, “Map of Life” and activity plan developed in consultation with the resident/family/whanau as appropriate. There is a co-ordinated approach to the six monthly review of the activity care plan. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.4a Care plans are evaluated by the registered nurses six monthly or when changes to care occur as sighted in five of seven care plans sampled. Two psychogeriatric residents have not been at the service six months. Short-term care plans for short term needs are evaluated regularly and either resolved or added to the long-term care plan as an on-going problem. The multidisciplinary review involves the Facility and Clinical managers RN, DT, unit co-ordinator, physio, GP and family/resident. The family are notified of the outcome of the review by phone call if they have been unable to attend the MDT (evidenced in the family contact form). There is at least a three monthly review by the medical practitioner. All residents are seen at least monthly. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Each unit has a locked clinic where medication trolleys, pharmaceuticals, clinical equipment and dressing supplies are kept. There is a medication competent list of  RNs and clinical assistants who administer medications. Other competencies include oxygen, blood sugar monitoring and insulin administration, PEG feeding and syringe driver competency. Robotic medications are delivered weekly and checked by the RN on arrival. Signed robotic checking forms are sighted in each unit. PRN medications are dispensed in pottles. All expiry dates are checked weekly. This is an improvement since the previous audit.  The hospital unit has a stock of hospital only medications. A weekly stocktake is completed. There is a supply of antibiotics for use as prescribed by the GP’s. There is a current standing order form. The standing orders list is current. Medication fridge temperatures are monitored weekly. Temperatures are monitored daily when vaccines are in the fridges. The service have two qualified vaccinators. Adrenaline is available for emergency use. Oxygen and suction is available. All oxygen cylinders are restrained. All eye drops are dated on opening. The controlled drugs register evidences weekly stocktakes and there are six monthly pharmacy audits. Medication administration observed in East (hospital) and Kowhai (hospital and psychogeriatric) evidenced compliance of medication administration standards. There are no gaps in 14 of 14 signing sheets sampled. This is an improvement from the previous audit. Telephone orders have been signed by the GP within the required timeframes. The medication manual includes rules for crushing medication, antibiotic guide and reducing antipsychotic use flowchart. There are no self-medicating residents.   Fourteen (six hospital and eight psychogeriatric) of 14 medication charts sampled have photo identification and allergies noted. All medication charts have been reviewed by the GP three monthly. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The relief cook on duty (interviewed) is knowledgeable in the food services policies and procedures for Bupa. The cook is supported by two kitchen hands on mornings and an evening kitchen hand. The national menus have been audited and approved by an external dietitian. Recipes are available on the intranet. The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes and dislikes. This is reviewed six monthly as part of the care plan review. Alternative choices are offered. Changes to residents’ dietary needs, weight loss and swallowing difficulties are communicated to the kitchen as reported by the cook interviewed. A kitchen communication diary is used between all staff. Special diets being catered for include normal, soft diets, puree diets, vegetarian and religious preferences. Specialised plates and cutlery are available for residents to help promote independence with meals. Meals are delivered to the units in bain maries. Staff are observed serving well-presented meals. East (hospital) have a kitchenette with fridge, microwave, dishwasher and tea making facilities. There are nutritional snacks and “finger foods” available in all units. There are additional foods kept in the overnight fridge in the kitchen. All foods sighted in fridges are date labelled. Facility fridges and freezers are temperature monitored daily. All foods have temperature checks recorded daily. Inwards goods are temperature checked on arrival. There is a good workflow in the kitchen and adequate storage and equipment to cater for the number of meals produced daily. All meals and baking is done on site. A cleaning duties list is maintained (sighted). Chemicals are stored safely when the kitchen is unattended. All food services staff have attended food safety and hygiene training |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a current building warrant of fitness that expires 26 April 2014. There is an approved evacuation scheme. The maintenance person is employed full time. There is a maintenance reporting system and a 52 week planned maintenance programme that includes monthly hot water temperature monitoring. A building compliance audit is completed annually. Hoists have had a functional check. Electrical testing of equipment is current. The service has a vax machine and commercial cleaners are scheduled for regular carpet cleaning. The interior is well maintained. Renovations to the Kowhai unit are near completion. A wall separating two lounges within the unit has been removed to provide open plan lounge and dining areas. The nurse’s station is centrally located to allow continual observation. A risk management plan is in place to ensure the safety and management of residents in the unit. The grounds and gardens are maintained by an external contractor. There is safe access to secure gardens in the psychogeriatric units. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint policy is in place. 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 18 residents with bedrails on the restraint register and five residents in the hospital under environmental restraint due to the potential to abscond. There are no residents identified as requiring. Training has been provided around restraint, enablers and challenging behaviours. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, regional restraint meetings and at an organisational level.  Any restraint incidents including emergency restraint are discussed in the monthly restraint meetings. Environmental restraint is reviewed informally for each of the five residents monthly and formally three monthly. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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

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

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

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| **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 and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager’s report on quality indicators. Quality improvement- corrective action plans have been implemented throughout the year where indicators are above the benchmark including (but not limited to) UTIs January 2014. Quality action forms have been established including (but not limited to) strategies to reduce scabies, as a result they have not had any cases for last eight months.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.  A scabies outbreak occurred in the rest home (2013), three residents were infected. A special report was completed and toolbox talk for staff provided. This was well managed and resolved. The service managed effectively a norovirus outbreak (Onset 25/12/13 that affected 41 residents and 18 staff. The last case 9/1/14. Regular meetings were held, an outbreak management report and debriefing was held. Norovirus in-service was held with staff Jan 2014 (22 attended). |

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

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

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

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

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

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