

Bupa Care Services NZ Limited - Lake Wakatipu Home and Hospital

Current Status: 4 April 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

Bupa Lake Wakatipu provides care for up to 35 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 31 residents.

Since Lake Wakatipu was acquired by Bupa July 2012, the service worked through the framework established by the Bupa Quality and Risk team to enable the service to implement Bupa policy and processes in a systematic way. These systems and processes are now well established with support by the Operations Manager and Bupa Quality and Risk team.

Residents and relatives interviewed spoke positively about the care and support provided at Lake Wakatipu.

Lake Wakatipu has an experienced Care Home manager (RN) that has been in the role for the last 2.5 months. She has worked in aged care management for a number of years. The manager is supported by a Clinical Manager (RN) whom is new to the role.

The service has addressed seven of the ten shortfalls identified at the previous audit. Further improvements continue to be required around, care planning interventions, updating care plans following changes in health status and aspects of medication documentation.

This audit also identified improvements required around open disclosure, and staff files.

Audit Summary as at 4 April 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

Indicator	Description	Definition
	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 4 April 2014

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

Organisational Management as at 4 April 2014

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

Continuum of Service Delivery as at 4 April 2014

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

Safe and Appropriate Environment as at 4 April 2014

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

Restraint Minimisation and Safe Practice as at 4 April 2014

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

Infection Prevention and Control as at 4 April 2014

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

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

Legal entity name:	Bupa Care Services NZ Limited
Certificate name:	Bupa Care Services NZ Limited - Lake Wakatipu Home and Hospital
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Lake Wakatipu Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 April 2014 End date: 4 April 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	31

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	3
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	16	Total audit hours off site	8	Total audit hours	24
Number of residents interviewed	6	Number of staff interviewed	8	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	35	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Thursday, 8 May 2014

Executive Summary of Audit

General Overview

Bupa Lake Wakatipu provides care for up to 35 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 31 residents; including 14 hospital residents and 17 rest home residents (including two residents under respite contracts). Since Lake Wakatipu was acquired by Bupa July 2012, the service worked through the framework established by the Bupa Quality and Risk team to enable the service to implement Bupa policy and processes in a systematic way. These systems and processes are now well established with support by the Operations Manager and Bupa Quality and Risk team.

Residents and relatives interviewed spoke positively about the care and support provided at Lake Wakatipu.

Lake Wakatipu has an experienced Care Home manager, registered nurse (RN) that has been in the role for the last 2.5 months. She has worked in aged care management for a number of years. The manager is supported by a Clinical Manager (RN) whom is new to the role.

The service has addressed seven of the ten shortfalls identified at the previous audit. Further improvements continue to be required around, care planning interventions, updating care plans following changes in health status and aspects of medication documentation.

This audit also identified improvements required around open disclosure, and staff files.

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. There is an improvement required around the reporting of medication errors. 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.

The tikanga flipchart has been updated at Lake Wakatipu to reflect local Iwi and contact details of tangata whenua and this is an improvement on previous audit.

Outcome 1.2: Organisational Management

Lake Wakatipu has established the Bupa quality and risk management system further since previous audit. Quality and risk performance is reported across the facility meetings, and also to the organisation's management.

Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Lake Wakatipu is benchmarked in two of these (rest home 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 necessary if incidents are above the benchmark. However, an improvement is required around the reporting of medication errors.

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

Outcome 1.3: Continuum of Service Delivery

The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around care plans and updating care plans following evaluations. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around medication administration. The activities programme is facilitated by an activities coordinator and residents and families report satisfaction with the activities programme. The programme includes significant community engagement including competitions with other aged care facilities in the area. The cook cooks all food on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans.

Outcome 1.4: Safe and Appropriate Environment

There is a maintenance person who is shared with the connecting hospital (DHB) to provide reactive and preventative maintenance. The Bupa comprehensive maintenance schedule and checks are up to date and this is an improvement on previous audit. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires on 1-Jul-2014. Electrical equipment is checked annually. All medical equipment was calibrated and all hoists and electric beds are checked and serviced. A new call-bell system was installed in July. Hot water temperatures are monitored monthly and are at 45 degrees and below, this is an improvement on previous audit.

Outcome 2: Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has one resident on the register with an enabler in the form of bedrails. The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service currently has two residents in the hospital assessed as using a restraint (two bedrails). A register for each restraint is completed that includes a three-monthly evaluation. The previous shortfall has been addressed. The restraint standards are being implemented and implementation is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings.

Outcome 3: Infection Prevention and Control

The infection control (IC) programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	5	1	0	0
Criteria	0	38	0	5	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	31
Criteria	0	0	0	0	0	0	0	57

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Medication incidents reviewed for the last four months identified that three of six did not identify that family were informed.	Ensure family are informed of incidents including medication errors.	180
HDS(C)S.2008	Standard 1.2.3:	The organisation has an	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Quality And Risk Management Systems	established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.				
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	(i) Not all incidents were discussed at the quality meeting, for example: the medication errors were not included in the incident stats discussed at the February quality meeting. Therefore, corrective actions were not documented as occurring. (ii) A corrective action plan was established around the need for a new hoist July 2014. While this was implemented, the standing hoist that staff identified as unsafe remained in the hallway for use without being managed through the hazard management system and corrective action process	Ensure corrective actions are established and followed through where areas of non-compliance are identified	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the	PA Low	Two staff files lacked completed orientations, although advised these were completed.	Ensure orientations are followed up with staff to ensure these are signed off and kept on file.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		service provided.				
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	(i)One hospital resident has no care plan interventions for identified needs including challenging behaviour, a history of seizures and pain (link 1.3.8.3). (ii) The three hospital resident files sampled have short-term needs identified in progress notes but no short-term care plan.	(i)Ensure care plans document interventions for all identified area of need. (ii) Ensure short-term care plans are used for all short-term needs.	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	One hospital resident had pain identified in the care plan evaluation in July 2013 and January 2014 and the care plan had not been updated to include this.	Ensure care plans are updated when changes are identified.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and	PA Low	Two of ten medication charts sampled have non-packaged regular	Ensure medications are signed for when administered as prescribed.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications prescribed that have not always been signed as administered.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA
Evidence: The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa's facilities. Local Iwi and contact details of tangata whenua are to be identified at each facility. The ADHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. The tikanga flipchart has been updated at Lake Wakatipu to reflect local Iwi and contact details of tangata whenua and this is an improvement on previous audit. There is currently one resident that identifies as Maori and a cultural assessment to identify specific cultural needs/information has been completed.

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

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

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

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

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

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

Attainment and Risk: PA Low

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 clinical manager and registered nurse interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for March 2014 identified that eight of eight incident forms demonstrated that family were notified. Medication incidents reviewed for the last four months identified that three of six did not identify that family were informed.

D16.4b: All five (three rest home, two hospital) relatives interviewed stated that they are always informed when their family members health status changes.

There is a Bupa residents/relatives association that provides a strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. Meeting minutes were sighted at Lake Wakatipu. There is also a Bupa NZ communications manager. This person's role is to keep people informed and engaged about Bupa NZ's strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for March 2014 identified that eight of eight incident forms demonstrated that family were notified.

Finding:
Medication incidents reviewed for the last four months identified that three of six did not identify that family were informed.
Corrective Action:
Ensure family are informed of incidents including medication errors.
Timeframe (days): 180 (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.

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with four rest home and two hospital residents and five relatives confirmed they were provided with information on complaints and complaints forms. 2013 complaints were reviewed and included 17 written complaints (12 of which was from one relative) and four verbal complaints. All were well documented including</p>

investigation, follow up letter and resolution. There have been no reported complaints in 2014.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

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.

Lake Wakatipu has set specific quality goals for 2014 including (but not limited to); a) reduce medication errors across the facility from 28 in 2013 to zero in 2014, b) reduce increased focus on care of residents with dementia with emphasis on activities to reduce challenging behaviours and restraint incidents by 50% (from 46 behaviour incidents & six restraint incidents in 2013 to 23 and three respectively in 2014 and c) Provide residents with warm toast at breakfast with 75% residents indicating satisfaction with the resident satisfaction survey (2013 survey results indicated 52% were satisfied). Strategies are in place for each goal and progress is reported quarterly with the February progress report documented.

Since Lake Wakatipu was acquired by Bupa July 2012, the service has been working through the framework established by the Bupa Quality and Risk team to enable the service to implement Bupa policy and processes in a systematic way. These systems and processes are now well-established with support by the Operations Manager and Bupa Quality and Risk team.

Bupa Lake Wakatipu provides care for up to 35 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 31 residents; including 14 hospital residents and 17 rest home residents (including two residents under respite contracts) across the 35 swing beds. Under the medical component of their certificate there are two residents including one palliative care and one young physical disability (YPD) resident.

The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Lake Wakatipu is part of the southern (2) Bupa region which currently includes five facilities. The managers in the region teleconference weekly. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Lake Wakatipu and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on-going progress to meeting their goals. A forum is held every six months (with national conference including all the Bupa managers).

The organisation has a Clinical Governance group. The committee meets two monthly. The committee reviews the past and looking forward. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. Feedback is provided to managers at forums and also to staff through newsletters (sighted at Lake Wakatipu). 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).

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.

Lake Wakatipu has an experienced Care Home manager (RN) that has been in the role for the last 2.5 months. She has worked in aged care management for a number of years. The manager is supported by a Clinical Manager (RN) that is new to the role, but has been at Lake Wakatipu as a registered nurse for a number of years. There are job descriptions for both positions that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. The clinical manager returned from a Bupa Clinical Manager's forum on the day of audit.

ARC, D17.3di (rest home and hospital), the manager and clinical manager has maintained at least eight hours annually of professional development activities related to managing a hospital

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Lake Wakatipu has established the Bupa quality and risk management system further since previous audit. Quality and risk performance is reported across the facility meetings, 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. Bupa policies and procedures have been implemented throughout the year. A number of core clinical practices also have education packages for staff, which are based on their policies. These are implemented at Lake Wakatipu. 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. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule.

Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the two monthly staff meeting at Lake Wakatipu and the two monthly quality committee. The monthly FM/CM meeting also includes a thorough review of incidents/complaints etc. Weekly reports by facility manager to Bupa operations manager and month quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation.

There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home/hospital and staff incidents/accidents. The service has linked the complaints process with its quality management system. Weekly and monthly manager reports include complaints. Infection control is included in the quality 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 is an agenda item at the quality committee.

The previous audit identified improvements required around ensuring meeting minutes include discussion of quality data collected, trends and corrective actions identified are followed through to improve on clinical indicators. Improvements have been made in this area and discussion of quality data was noted in meeting minutes. However, it was identified that not all incidents were discussed at the quality meeting, for example: the medication errors were not included in the incident stats discussed at the February quality meeting.

The service collects data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. The service has implemented a number of corrective actions. An action plan was established around completing monitoring forms and resident clothes (as a result of survey feedback). A resident satisfaction survey was last completed December 2013 with 71% overall satisfied. Action plans were established as a result of the feedback and discussed with residents. A corrective action plan was established around the need for a new hoist July 2014. While this was implemented, the standing hoist that staff identified as unsafe remained in the hallway for use without being managed through the hazard management system.

The service also implements 'quality indicator - corrective action plans' (QI-CAP) where incidents/infections are above the benchmark; e.g.: January and February 2014 included corrective action plans for increased falls, a CAP was established for a category one incident in the rest home in January and for an increase in hospital skin tears. Audit summaries and action plans are completed where a noncompliance is identified.

D19.3: There is an H&S and risk management programme in place (link 1.2.3.8). Hazard identification, assessment and management (160) policy guides practice. Bupa also has an H&S coordinator whom monitors staff accidents and incidents.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: The service collects data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. The service has implemented a number of corrective actions. An action plan was established around completing monitoring forms and resident clothes (as a result of survey feedback). A resident

satisfaction survey was last completed December 2013 with 71% overall satisfied. Action plans were established as a result of the feedback and discussed with residents. A corrective action plan was established around the need for a new hoist July 2014. While this was implemented, the standing hoist that staff identified as unsafe remained in the hallway for use without being managed through the hazard management system.

The service also implements 'quality indicator - corrective action plans' (QI-CAP) where incidents/infections are above the benchmark; e.g.: January and February 2014 included corrective action plans for increased falls, a CAP was established for a category one incident in the rest home in January and for an increase in hospital skin tears. Audit summaries and action plans are completed where a noncompliance is identified.

The previous audit identified improvements required around ensuring meeting minutes include discussion of quality data collected, trends and corrective actions identified are followed through to improve on clinical indicators. Improvements have been made in this area and discussion of quality data was identified in meeting minutes. However, it was identified that not all incidents were discussed at the quality meeting, for example: the medication errors were not included in the incident stats discussed at the February quality meeting. Therefore, corrective actions were not documented as occurring.

Finding:

(i) Not all incidents were discussed at the quality meeting, for example: the medication errors were not included in the incident stats discussed at the February quality meeting. Therefore, corrective actions were not documented as occurring. (ii) A corrective action plan was established around the need for a new hoist July 2014. While this was implemented, the standing hoist that staff identified as unsafe remained in the hallway for use without being managed through the hazard management system and corrective action process

Corrective Action:

Ensure corrective actions are established and followed through where areas of non-compliance are identified

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The completed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Incident forms reviewed for March 2014 (eight forms) identified clinical follow up by a registered nurse/clinical manager and monitoring (such as neurological observations) having been undertaken when indicated. Opportunities for improvement are documented on the incident form by clinical manager and this is an improvement since previous audit. Six medication error incident forms across four months also identified clinical follow up at the time of the identified incident (link 1.1.9.1 and 1.2.3.8).

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. Quality indicator- corrective action plans are established when they were above the benchmark, including (but not limited to); behaviours August and October 2013, medication errors August, September and December 2013.

Discussions with service management, overall confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>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).</p> <p>The service has implemented the Bupa orientation programme 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.</p> <p>Staff interviewed (three caregivers, one registered nurse) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Five staff files were requested for view (clinical manager, registered nurse, three caregivers, and activity therapist). Two staff files lacked completed orientations, although advised these were completed.</p> <p>Appraisals, compulsory training sessions and staff competencies are up to date and this is an improvement on previous audit.</p> <p>Interviews with the manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures).</p> <p>There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an RN training day</p>

provided through Bupa that covers clinical aspects of care - e.g. delirium, dementia. 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. The RNs are due commence this.

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

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, restraint, wound management, and subcutaneous fluids.

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

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

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

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

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

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

Timeframe (days): (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.

Attainment and Risk: PA Low

Evidence:

The service has implemented the Bupa orientation programme 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. Staff interviewed (three caregivers, one registered nurse) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Five staff files were requested for view (clinical manager, registered nurse, three caregivers, and activity therapist).

Finding:

Two staff files lacked completed orientations, although advised these were completed.

Corrective Action:

Ensure orientations are followed up with staff to ensure these are signed off and kept on file.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (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. A report is provided fortnightly from head office that includes hours and whether hours are over and above. There is a registered nurse across 24/7. The facility manager and clinical manager are both registered nurses. Interviews with three caregivers that work across the facility identified that staffing levels were overall good.

Interviews with six residents and five relatives stated overall that staffing was adequate.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. This was included for all five files sampled (two from the rest home and three from the hospital) including a review of the previous assessment for the rest home respite resident on the first day of this admission. This is an improvement since the previous audit. Within three weeks, the care plan is developed in three of five files sampled. One rest home resident is on respite care and one hospital resident is new to the service.

D16.2, 3, 4: In three of five files sampled (two from the hospital, one from the rest home,) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. One rest home resident is on respite care and one hospital resident is new to the service so they do not yet have a long-term care plan. Medical assessments are completed on admission by the general practitioner (GP) in five files sampled and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person.

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

D16.5e: Five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Five files identified integration of allied health and a team approach is evident in the five files. The GP interviewed spoke positively about the service and describes very effective communication processes. The GP interviewed reports that she is contacted promptly of any change to a resident's condition.

In three of five files, an activities coordinator has completed activity assessments and the activities sections of the care plans. One rest home resident is on respite care and one hospital resident is new to the service.

Tracer Methodology hospital:

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

Tracer methodology rest home:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: The previous audit identified that one long term care plan was incomplete. All five resident care plans sampled for this audit had all sections completed. This is an improvement since the previous audit. The previous audit also identified that one care plan did not record specific interventions as detailed by speech language therapist until two months after review. Four of the five care plans sampled for this audit (two from the rest home and three from the hospital) had interventions relating to all identified areas of need. This shortfall continues to require addressing. Short-term care plans are well used for UTI's, weight loss and wounds. However, the three hospital resident files sampled have short-term needs identified in progress notes but no short-term care plan. This is an area requiring improvement.

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

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

Attainment and Risk: PA Moderate
Evidence: All five resident care plans sampled for this audit had all sections completed. This is an improvement since the previous audit. The previous audit also identified that one care plan did not record specific interventions as detailed by speech language therapist until two months after review. Four of the five care plans sampled for this audit (two from the rest home and three from the hospital) had interventions relating to all identified areas of need. Short-term care plans are well used for UTI's, weight loss and wounds.
Finding: (i)One hospital resident has no care plan interventions for identified needs including challenging behaviour, a history of seizures and pain (link 1.3.8.3). (ii) The three hospital resident files sampled have short-term needs identified in progress notes but no short-term care plan.
Corrective Action: (i)Ensure care plans document interventions for all identified area of need. (ii) Ensure short-term care plans are used for all short-term needs.

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

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

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

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

Attainment and Risk: FA

Evidence:

The registered nurses complete residents' care plans. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The three caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist (link 1.4.2), wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Six residents interviewed (two hospital and four rest home) and five families interviewed (two from the hospital and three from the rest home) were complimentary of care received at the facility.

The care being provided is consistent with the needs of residents, this is evidenced by discussions with three caregivers, and five families interviewed, one registered nurse, the facility manager and the clinical manager.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for seven residents. This includes two pressure areas. All have an assessment, management plan and evidence of timely review. The clinical manager and registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

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

During the tour of facility, it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>There is one activities coordinator who works 35 hours per week and provides a combined programme for the rest home and hospital level residents includes one to one activities for residents who require these. On the day of audit, residents throughout the facility were observed being actively involved with a variety of activities. The programme is developed monthly and displayed in large print. Residents have an assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review/evaluated. The programme includes networking within the community with social clubs, schools etc. On, or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six monthly as part of the lifestyle care plan review/evaluation. A record is kept individual residents activities. There are recreational progress notes in the resident’s file that the activity officers complete for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in all areas of the facility, participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: PA Low
Evidence: Support plans are reviewed and evaluated by the registered nurse at least six monthly in three of five files sampled (one rest home resident is on respite care and one hospital resident is new to the service). Plans are updated when changes to care occur in two of the three plans. One hospital resident had pain identified in the care plan evaluation in July 2013 and January 2014 and the care plan was not updated to include this. This previously identified shortfall continues to require improvement. There is at least a one- three monthly review by the medical practitioner. There are short-term care plans to focus on acute and short-term issues (link 1.3.5.2). From two of the five-sample group of resident's notes the short-term care plans are well used and comprehensive. Examples of STCPs in use included; infections, wounds, pain. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

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

Timeframe (days): (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.

Attainment and Risk: PA Low

Evidence:

Support plans are reviewed and evaluated by the registered nurse at least six monthly in three of five files sampled (one rest home resident is on respite care and one hospital resident is new to the service. Plans are updated when changes to care occur in two of the three plans. There is at least a one- three monthly review by the medical practitioner.

There are short-term care plans to focus on acute and short-term issues (link 1.3.5.2). From two of the five-sample group of resident's notes the short-term care plans are well used and comprehensive. Examples of STCPs in use included; infections, wounds, pain.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

Finding:

One hospital resident had pain identified in the care plan evaluation in July 2013 and January 2014 and the care plan had not been updated to include this.

Corrective Action:

Ensure care plans are updated when changes are identified.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Medications are managed appropriately in line with accepted guidelines. The medications are stored in a locked trolley in the treatment room. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses and enrolled nurses administer medications and all must have passed their medication competency (link 1.2.3.8 relating to medication errors).

The service uses four weekly blister packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Blister packs are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Registered nurses and enrolled nurses are peer reviewed annually and caregivers are selected by the clinical manager and trained in medication administration and

competency checked annually. Only those staff deemed competent administer medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off.

All 'medication competent' staff are responsible for medication administration in all areas. Competency tests are done annually and if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers

Medication – self administration policy (098) states self –administration of medication will be documented in the residents care plan.

There are currently no residents self-administering.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. There is no evidence of transcribing and this is an improvement since the previous audit. All medication charts sampled have one signature per medication. All PRN medication prescriptions include an indication for use and a frequency for use. These are improvements since the previous audit. Signing sheets correspond to instructions on the medication chart for eight of ten medication charts sampled. This is a previously identified shortfall that continues to require addressing. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies,

The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the residents' general practitioner at least three monthly. Charts are easy to read and current. Medication audits are completed six monthly. The medication fridge is monitored daily and temperatures are all within the acceptable range. The controlled drug medications held have the correct labelling and prescribed for the resident. There is a weekly controlled drug physical check. All opened eye drops and ointments are dated.

D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: PA Low

Evidence:

Medications are managed appropriately in line with accepted guidelines. The medications are stored in a locked trolley in the treatment room. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses and enrolled nurses administer medications and all must have passed their medication competency (link 1.2.3 relating to medication errors). The service uses four weekly blister packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Blister packs are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

There is no evidence of transcribing and this is an improvement since the previous audit. All medication charts sampled have one signature per medication. All PRN medication prescriptions include an indication for use and a frequency for use. These are improvements since the previous audit. Residents/relatives interviewed stated they are kept informed of any changes to medications. Resident medications are reviewed by the residents' general practitioner at least three monthly. Charts are easy to read and current. Medication audits are completed six monthly.

The medication fridge is monitored daily and temperatures are all within the acceptable range. The controlled drug medications held have the correct labelling and prescribed for the resident. There is a weekly controlled drug physical check. All opened eye drops and ointments are dated.

D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Finding:

Two of ten medication charts sampled have non-packaged regular medications prescribed that have not always been signed as administered.

Corrective Action:

Ensure medications are signed for when administered as prescribed.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'.</p> <p>The national menus have been audited and approved by an external dietitian and this last occurred on 15 May 2013.</p> <p>The service employs four kitchen staff including two cooks. The main kitchen supplies meals for the rest home and hospital and also for the attached DHB hospital and meals on wheels.</p> <p>All of the four staff on the kitchen team at Lake Wakatipu Home and Hospital are currently completing NZQA food safety certificates.</p> <p>The service has a large workable kitchen that contains a walk-in pantry, freezer, three fridges, an air steam oven, bain marie, microwave, commercial oven and hot plates.</p> <p>There is a preparation area and receiving area.</p> <p>Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number audits completed include; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit.</p> <p>The kitchen produces large print menus with pictures of the main meal each day to make them more able to be understood by residents. Residents are able to request an alternative if they do not wish to have the prepared meal.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board, which can be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets and diabetics.</p> <p>There is a kitchen manual that includes (but is not limited to) hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety.</p>

Daily temperature checks of the chiller, freezers, bain marie and dishwasher are maintained.
The head cook attends regular teleconferences and an annual cook's conference with other Bupa cooks.
D19.2 Staff have been trained in safe food handling.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a maintenance person who is shared with the connecting hospital (DHB) to provide reactive and preventative maintenance. The Bupa comprehensive maintenance schedule and checks have up to date and this is an improvement on previous audit. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires on 1-Jul-2014. Electrical equipment is checked annually. All medical equipment was calibrated and all hoists and electric beds are checked and serviced. A new call-bell system was installed in July. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are handrails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens are attractive. There is an internal courtyard and garden with raised garden beds, furniture and plenty of shade. There is wheelchair access to all areas. Hot water temperatures are monitored monthly and are at 45 degrees and below, this is an improvement on previous audit.</p> <p>ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. Interviews with three caregivers, and RN confirmed there was adequate equipment.</p>

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: <p>Restraint policy (251) states the organisations philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however we acknowledge that there may be occasions when a resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated'. There is a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. Restraint/enablers are also discussed in the quality meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</p>

The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has one resident on the register with an enabler in the form of bedrails. The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service currently has two residents in the hospital assessed as using a restraint (two bedrails). A register for each restraint is completed that includes a three-monthly evaluation. The restraint standards are being implemented and implementation is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings.

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

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

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

Services use restraint safely

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

Attainment and Risk: FA
Evidence:
The restraint coordinator is the clinical manager and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plans identifies the specific interventions or strategies to try (as appropriate) before implementing restraint. Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed monthly

during the facility restraint meetings and also as part of the three-monthly restraint reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions are initiated.

The two resident's files refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans and care summaries reviewed in two hospital residents' files with restraint identified observations and monitoring as per their monitoring schedules. This is an improvement on previous audit. Restraint use and any restraint incidents are reviewed through the three monthly assessment evaluation, quality meetings and six-monthly multi-disciplinary meetings and includes family/whanau input.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register 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 staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

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