# Beetham HealthCare Limited

## Current Status: 1 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification 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

Beetham Health Care has been in operation since September 2011 and is certified to provide hospital (medical and geriatric), rest home and dementia care level care for up to 42 residents. Beetham Health Care is privately and locally owned. The chief executive officer is a registered nurse with a current practising certificate. He has a significant amount of experience in the aged care environment. He is supported by an acting clinical services manager and a quality co-ordinator who have experience in aged care. Staff remains stable. There are systems to guide appropriate care for residents. A strategic business plan and quality risk programme is in place and implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

There are improvements required around aspects of verbal concerns, human resources, interventions, evaluations, Maori health care plans and medication documentation.

## Audit Summary as at 1 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 1 July 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 1 July 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 1 July 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 1 July 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 1 July 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 1 July 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. |

## Audit Results as at 1 July 2014

### Consumer Rights

Beetham Health Care provides individual care for their residents. There is a Maori Health Plan and cultural safety policy supporting practice. Policies are in place to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) information is displayed and readily available to residents and family/whanau. There is an improvement required around the management of verbal concerns. Care plans accommodate the choices of residents and/or their family. Residents and family interviewed verified on-going involvement with community links.

### Organisational Management

Beetham Health Care has a quality and risk management system to support the provision of clinical care. Components of the quality management system are discussed at the monthly staff and management meetings. This includes a summary of incidents, infections and internal audit results. An annual relative satisfaction survey is completed and there are three monthly relative and resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The service has an on-site career force assessor. The staffing policy aligns with contractual requirements and includes skill mixes. There improvements required around job descriptions and staff appraisals.

### Continuum of Service Delivery

Residents/family/whanau receive a comprehensive information pack on entry to the service. Assessments, care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are evaluated six monthly. The resident and family confirm they are involved in the care planning process and are complimentary about the staff and standard of care provided. Short term care plans are in use for changes in health status. There are improvements required around Maori health care plans, short term care plans, risk assessment reviews and documentation of interventions to reflect the resident’s current needs.

The two activity co-ordinators provide an activities programme for the rest home, hospital and dementia care residents that is varied, interesting and involves volunteers and community visitors.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. There is an improvement required around aspects of medication documentation. The GP reviews the medication chart three monthly.

Meals are prepared on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided

### Safe and Appropriate Environment

Beetham Health Care has a current warrant of fitness. Fire equipment checks are conducted by an external fire safety contractor. There are six monthly fire drills. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids or hospital level lazy boy chairs. The hallways are wide and have hand rails appropriately placed. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There is a preventative and planned maintenance schedule in place. There are civil defence supplies readily accessible. There is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

### Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place. Any restraint/enabler use is recorded in an auditable format. There are no restraints in use. Thirteen enablers are in use. There is a restraint co-ordinator who has attended external training and provides staff restraint minimisation and safe practice education on orientation and annually.

### Infection Prevention and Control

The infection control 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 (acting clinical services manager) is responsible for coordinating education and training for staff. The service has access to infection control consultants and specialists as required. There is a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **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:** | Beetham HealthCare Limited |
| **Certificate name:** | Beetham HealthCare Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Beetham HealthCare | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 1 July 2014 | **End date:** | 2 July 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:** | 34 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXXXX | **Hours on site** | 14 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXXXX | **Total hours on site** | 14 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 28 | Total audit hours off site | 16 | Total audit hours | 44 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 11 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 40 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXX, 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 | Not Applicable |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Tuesday, 5 August 2014

## **Executive Summary of Audit**

**General Overview**

Beetham Health Care has been in operation since September 2011 and is certified to provide hospital (medical and geriatric), rest home and dementia care level care for up to 42 residents. On the day of the audit there were 14 hospital residents, 14 rest home residents and six dementia care. Beetham Health Care is privately and locally owned. The chief executive officer is a registered nurse with a current practising certificate. He has a significant amount of experience in the aged care environment. He is supported by an acting clinical services manager and a quality co-ordinator who have experience in aged care. Staff remains stable. There are systems to guide appropriate care for residents. A strategic business plan and quality risk programme is in place and implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

There are improvements required around aspects of verbal concerns, human resources, interventions, evaluations, Maori health care plans and medication documentation.

**Outcome 1.1: Consumer Rights**

Beetham Health Care provides individual care for their residents. There is a Maori Health Plan and cultural safety policy supporting practice. Policies are in place to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) information is displayed and readily available to residents and family/whanau. There is an improvement required around the management of verbal concerns. Care plans accommodate the choices of residents and/or their family. Residents and family interviewed verified on-going involvement with community links.

**Outcome 1.2: Organisational Management**

Beetham Health Care has a quality and risk management system to supports the provision of clinical care. Components of the quality management system are discussed at the monthly staff and management meetings. This includes a summary of incidents, infections and internal audit results. An annual relative satisfaction survey is completed and there are three monthly relative and resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The service has an on-site career force assessor. The staffing policy aligns with contractual requirements and includes skill mixes. There improvements required around job descriptions and staff appraisals.

**Outcome 1.3: Continuum of Service Delivery**

Residents/family/whanau receive a comprehensive information pack on entry to the service. Assessments, care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are evaluated six monthly. The resident and family confirm they are involved in the care planning process and are complimentary about the staff and standard of care provided. Short term care plans are in use for changes in health status. There are improvements required around Maori health care plans, short term care plans, risk assessment reviews and documentation of interventions to reflect the resident’s current needs.

The two activity co-ordinators provide an activities programme for the rest home, hospital and dementia care residents that is varied, interesting and involves volunteers and community visitors.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. There is an improvement required around aspects of medication documentation. The GP reviews the medication chart three monthly.

Meals are prepared on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided

**Outcome 1.4: Safe and Appropriate Environment**

Beetham Health Care has a current warrant of fitness. Fire equipment checks are conducted by an external fire safety contractor. There are six monthly fire drills. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids or hospital level lazy boy chairs. The hallways are wide and have hand rails appropriately placed. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There is a preventative and planned maintenance schedule in place. There are civil defence supplies readily accessible. There is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

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

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place. Any restraint/enabler use is recorded in an auditable format. There are no restraints in use. Thirteen enablers are in use. There is a restraint co-ordinator who has attended external training and provides staff restraint minimisation and safe practice education on orientation and annually.

**Outcome 3: Infection Prevention and Control**

The infection control 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 (acting clinical services manager) is responsible for coordinating education and training for staff. The service has access to infection control consultants and specialists as required. There is a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 39 | 0 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 4 | 2 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Meeting minutes sighted report; a) resident verbal concerns in January 2014; b) resident verbal concerns regarding the cleanliness of bedrooms in April 2014; c) relative concern regarding end of life cares in April 2014 however the relative requested no written follow-up; and d) a family member concern regarding security of the front door. There is documented evidence of corrective action as a result of the concerns. | Ensure verbal concerns are entered into the complaints register. | 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 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Three of seven staff files did not contain a signed job description. One of seven files did not have an 11th week performance appraisal completed. One of seven files did not evidence an annual performance appraisal. | Ensure employment policies and processes are followed. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low |  |  |  |
| 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 Low | Three out of four Maori residents do not have an individual Maori health plan as per policy. | Ensure Maori health plans are in place for Maori residents. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The following shortfalls were identified; (i) One rest home resident diagnosed with XXXX in February 2014 did not have a XXXX management plan in place or XXXX status linked to the long term care plan; (ii) One rest home resident does not evidence a monthly weight from January 2013 to May 2014 and the same resident has had weight loss; There is no evidence of weekly weighs as per the short term care plan; (iii) Risks associated with the use of enablers are not documented in the care plan of three out of three resident files sampled who use enablers; (iv) Two of two dementia care resident files sampled do not have individualised 24 hour behaviour management plans that include alternative strategies and activities for the de-escalation of behaviours. | Ensure interventions are documented to reflect the resident’s current needs. | 60 |
| 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 1.3.8.2 | 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. | PA Low | (i)Risk assessments have not been reviewed six monthly as part of the care plan review process for continence (two hospital, one rest home), pain (three hospital and one rest home), pressure area (one hospital and one rest home) and falls (one hospital and one rest home). (ii) Five of eight short term care plans (two hospital, two rest home and one dementia) sighted in resident files have not been evaluated or closed off as resolved. | (i) Ensure risk assessments are reviewed at least six monthly or more frequently as required. (ii) Ensure short term care plans are evaluated within a timely manner | 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i)One CD regular medication signing chart written on PRN signing chart and signed by one medication competent person (not a RN). (ii) Alternative medication used is not recorded on one of 16 medication charts. (iii) There is no medication error report written for one incorrect dose of controlled drug . | (i) Ensure that all controlled drug regular medications are charted on the regular medications signing chart and countersigned where an RN is not administering the controlled drug; (ii) Ensure alternative medications used are recorded on the medication chart.; (iii) Ensure medication errors are reported; | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Beetham Health Care has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the annual in-service programme. Interview with three caregivers (who work across rest home, hospital and dementia) demonstrate an understanding of the Code. Code of rights training was provided February 2014 (10 attended). Code of Rights training is scheduled annually and all staff attend at least two yearly. Residents interviewed (two rest home and one hospital) and relatives (two rest home and three hospital, one dementia care) confirm staff respect privacy, and support residents in making choice where able.

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

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

**Attainment and Risk:** 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 1.1.2: Consumer Rights During Service Delivery **(**HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed at the main entrance to the facility. The monthly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents and relatives interviewed have been provided around the Code and an information session was provided by an external advocate in February 2014.   
D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission. The clinical services manager and administration manager describe discussing the information pack with residents/relatives on admission.   
D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.t

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Staff could describe aspects of abuse and neglect. Training on privacy and dignity was provided in December 2012 and scheduled again for September 2014. A customer satisfaction survey is completed annually (February 2014) with a 56% return that includes feedback on privacy, dignity and respect. The resident meetings provide the opportunity for residents to raise issues (minutes sighted).  
D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with three caregivers who work across the rest home, hospital and dementia are unit are able describe how choice is incorporated into resident cares. There is a resident’s rights policy and staff attend in-service (January 2013). Interviews with residents and family members stated the care provided is very good and staff are respectful.

D4.1a: Eight resident files (two rest home, four hospital and two dementia) reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with resident/family/whanau involvement and integrated with the residents' care plan.

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

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

**Attainment and Risk:** 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 1.1.4: 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:**

A3.2: Beetham Health Care has a Maori health plan (dated June 2013) that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups including Maori primary health organisations and Maori health providers. Interpreter services are available as required. There are policies that guide staff in providing a culturally safe service. Maori staff are available to support and advise staff regarding the delivery of culturally safe care across the services (clinical, food, laundry, cleaning). Annual cultural safety training is scheduled for August 2014. Staff interviewed (11) across the services are able to describe how culturally acceptable care is delivered and the importance of family/whanau consultation/input. There are four Maori residents at the service. Ethnicity and tribal affiliation has been identified on admission. Three of four Maori residents do not have a specific Maori Health care plan as per policy (link 1.3.5.2).

D20.1i: There are policies that guide staff in providing a cultural safe service. Special events and occasions are celebrated and this could be described by staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.4.5 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs **(**HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

**Attainment and Risk:** FA

**Evidence:**

The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. The resident/family/whanau are invited to attend the care plan reviews. Discussions with three relatives inform values and beliefs are considered. Discussion with residents (two rest home and one hospital) and relatives (two rest home, three hospital, and one dementia care) confirm that staff take into account the residents culture and values.  
D3.1g: The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.   
D4.1c: Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs.

##### **Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)**

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

**Attainment and Risk:** 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 1.1.7: Discrimination **(**HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Job descriptions include responsibilities of the position (link 1.2.7). Staff meetings and RN meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Staff who do not attend the meeting are requested to read the minutes and sign when read. Interviews with the clinical services manager and two RN and one registered nurse confirm an awareness of professional boundaries. Interview with three caregivers (who work across rest home, hospital and dementia) could discuss professional boundaries in respect to resident’s belongings or gifts.

##### **Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)**

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

**Attainment and Risk:** 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 1.1.8: Good Practice **(**HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

**Attainment and Risk:** FA

**Evidence:**

Beetham Health Care has a suite of appropriate policies and procedures available to guide practice. There are regular staff meetings, RN meetings and more recently specific health care assistants meetings. Review of procedures, policies, practices are discussed and meeting minutes available. Staff who have not attended the meeting read and sign the minutes. There are set agenda items including health and safety, infection control, care planning and clinical matters, enablers, medications, accidents and incidents, education and audit outcomes.

There is a quality improvement programme being implemented that includes monitoring against clinical indicators. There is a culture of on-going staff development with the Career Force programme. There is evidence of external education being supported.   
  
ARC A2.2: Services are provided at Beetham Heath Care that adhere to the health & disability services standards.   
ARC D1.3: All approved service standards are adhered to.   
ARC D17.7c: There are implemented competencies for caregivers and registered nurses including but not limited to: medication, fire and safety and safe manual handling.   
Discussions with residents (two rest home and one hospital) and relatives (two rest home and three hospital, one dementia care) were positive about the care they receive. Interview with three HCAs and two RNs inform they are well supported by the clinical services manager, quality co-ordinator and management team.

##### **Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)**

The service provides an environment that encourages good practice, which should include evidence-based practice.

**Attainment and Risk:** 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 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

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

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

**Attainment and Risk:** FA

**Evidence:**

The policy on open disclosure states family/enduring power of attorney will be kept informed of any incident or accident. A next of kin contact sheet is held each resident file, documenting the dates families are contacted and the detail of what was communicated. Accident and incident forms document family are contacted following an adverse event in 18 of 18 forms viewed. Families are contacted (as documented) for any changes to health status, incidents/accidents, infections, GP visits and changes to care.   
All five family members interviewed report they are kept informed about their family’s health status.   
If necessary, interpreter services can be accessed through the District Health Board.

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.  
D16.4b: Relatives stated that they are informed when their family members health status changes.  
D11.3: The information pack is available in large print and 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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.9.4 (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 1.1.10: Informed Consent **(**HDS(C)S.2008:1.1.10)

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

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

**Attainment and Risk:** FA

**Evidence:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent and advocacy information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Two three HCAs and two RNs interviewed are familiar with the code of rights and informed consent when delivering resident cares. There are written general consents in the resident files for photo, medications, minor procedures and delivery of cares, choice, and advocacy. There are appropriately signed resuscitation authorisations in six of six resident files. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The GP confirms competence. Consents and resuscitation authorisation is reviewed and residents are informed they may withdraw or change consents at any time.   
D3.1.d: Discussion with family members identifies that the service actively involves them in decisions that affect their relative’s lives. Advance directives are completed for residents who are competent to make the decision.   
D13.1: There are eight signed admission agreements.

##### **Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)**

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed and readily available at the front entrance to the facility. Interviews with residents (two rest home and one hospital) confirm that they are aware of their right to access advocacy.  
D4.1d; Discussions with family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions.   
ARC D4.1e: The resident files include information on residents’ family/whanau and chosen social networks.

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

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

**Attainment and Risk:** 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 1.1.12: Links With Family/Whānau And Other Community Resources **(**HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

**Attainment and Risk:** FA

**Evidence:**

D3.1h: Interview with three residents and relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors are observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Interviews with three residents confirm the activity staff help them access the community such as going shopping, going on outings, and attending off-site church services.   
D3.1.e: Discussion with three caregivers, the activities officer, relatives and residents confirm residents are supported and encouraged to remain involved in the community and external groups.

##### **Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)**

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)**

Consumers are supported to access services within the community when appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.13: 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:** PA Low

**Evidence:**

The organisation’s complaints policy and procedures is in line with the requirements set by the Health and Disability Commissioner. Feedback forms/brochures and complaints and compliments are available at the entrance to the facility. There is a suggestions box. The quality co-ordinator is the organisations privacy officer.

There are no written complaints received since September 2013. Previous complaints detail the date the complaint was received; a description of the complaint; and the dates the complaint was acknowledged, investigated and resolved. The acknowledgment letter also offers advocacy support. Also included are recommendations that have resulted from the lodged complaint.  
Discussion regarding concerns and complaints is a set agenda item (as applicable) at staff and Quality meetings. Meeting minutes sighted report a) resident verbal concerns in January 2014. b) Resident verbal concerns regarding the cleanliness of bedrooms in April 2014 c) relative concern regarding end of life cares in April 2014 however the relative requested no written follow-up and d) a family member concern regarding security of the front door. There is documented evidence of corrective action as a result of the concerns. There is an improvement required around the registering of verbal concerns into the complaints register which was corrected on the day of audit.

Interviews with six families (two rest home, one dementia, three hospital) confirm their understanding of the importance of lodging complaints/concerns and their understanding that a process for managing complaints is in place. Interviews with three of three health care assistants (HCA)s and two registered nurses (RN)s confirm their understanding of the complaints process.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

E4.1biii.There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:   
1. Minimising restraint.  
2. Behaviour management.  
3. Complaint policy.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Meeting minutes sighted report; a) resident verbal concerns in January 2014; b) resident verbal concerns regarding the cleanliness of bedrooms in April 2014; c) relative concern regarding end of life cares in April 2014 however the relative requested no written follow-up; and d) a family member concern regarding security of the front door. There is documented evidence of corrective action as a result of the concerns.

**Finding:**

Meeting minutes sighted report; a) resident verbal concerns in January 2014; b) resident verbal concerns regarding the cleanliness of bedrooms in April 2014; c) relative concern regarding end of life cares in April 2014 however the relative requested no written follow-up; and d) a family member concern regarding security of the front door. There is documented evidence of corrective action as a result of the concerns.

**Corrective Action:**

Ensure verbal concerns are entered into the complaints register.

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A strategic business plan (2014 to 2017) is in place, which the CEO reports is a working document that is regularly updated by the directors. Four key strategic goals are included in the strategic plan as follows financial and budget, improvement and quality assurance, achieving excellence in service and providing high quality of life for the residents. There are timeframes and responsibilities for each goal. The strategic plans are signed off by the board of three directors (accountant, DHB (RN) representative and a company accountant). Beetham Health Care mission is: to provide a quality, homely environment in which the frail elderly, and/or confused elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed.  
Beetham Health Care is a modern purpose built facility that has been in operation almost three years. The business is privately and locally owned. The facility is divided into 36 hospital/rest home bed unit and a six bed dementia care unit. Occupancy on the day of audit is 14 rest home residents and 14 (includes one respite) hospital residents and six dementia care residents. The development of further services at Beetham Health Care is included in the strategic business plan and includes the build of a 30 bed medical facility and the provision of rest home level of care in the 12 serviced apartment building.

The chief executive officer (CEO) is a registered nurse with a current practising certificate. He has a significant amount of experience in the aged care environment and regularly attends professional development courses and Aged Care Association meetings and conferences relating to the management of the service, which exceeds eight hours per year. He is supported by a Quality co-ordinator and human resources manager who has been in the role two months. She is an experienced RN with two years previous experience as a clinical services manager in aged care. There is an RN/acting clinical service manager (casual RN) in place for the last six weeks who has been recently employed and experienced in aged care. There is a permanent clinical services manager commencing 21 July 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

During a temporary absence of the clinical services manager the Quality co-ordinator/human services manager (RN) provides cover. Both roles share the on-call after hours.

D19.1a: a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

**Attainment and Risk:** 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:** FA

**Evidence:**

Quality and risk management systems are in place. There is evidence of annual reviews of the quality and risk management plans at a governance level. There is a quality and Risk management plan 2014 in place, which covers policies and procedures, audits, infection control surveillance, complaints and compliments, human resources, customer feedback, incident reporting, restraint register, regular multidisciplinary client review, health and safety, and training and education programmes and service improvements. There are senior management meetings and quality meetings with written reports submitted to the CEO. The CEO provides a financial and monthly report to the board of directors. The service has annual quality goals which are reviewed (sighted). Quality goals are set with specific aims, responsibility and sign off as achieved. The quality programme is understood by staff (evidenced in interviews with 11 staff (three HCAs, two RNs, chef, and two activity co-ordinators and cleaner/laundry person).

Policies are in place for all aspects of the service. All policies are subject to a minimum of two-yearly reviews. Policies are readily available to staff in hard copy. Electronic versions of policies are also available. Policies are up-to-date and are linked to the Health and Disability Sector Standard (HDSS), current and applicable legislation, and evidenced-based best practice guidelines. A document management process controls policies and procedures. The review process is overseen by the quality co-ordinator. Manager.   
Service delivery is monitored through adverse event reporting, concerns/complaints management, infection control monitoring, accident/incident monitoring, health and safety compliance and enabler/restraint monitoring.   
Data is collected monthly for infection rates, incidents and accidents, skin integrity, medication errors and behaviour with results provided to staff. Enabler use is monitored by the restraint coordinator (RN).

There is an internal audit programme (schedule) that monitors key aspects of the service. Audits cover all aspects of service. There is a quality goal in place to maintain the internal audit programme due to gaps identified prior to the appointment of the quality co-ordinator. All audits have been completed and the schedule is now up to date.

Corrective action plans are developed and documented, dependant where opportunities for improvements are identified. Audit results are provided in the monthly quality meetings with evidence of discussions relating to any identified corrective actions (quality meeting minutes sighted). The service has a culture of continuous quality improvement. All staff interviewed report they are kept informed of quality improvements and corrective action plans. There is a planned meeting schedule which includes a newly formed Health and safety and infection control teams (including the restraint co-ordinator and quality co-ordinator).

The organisation has a risk management plan in place that documents and rates risks and control plans associated with the service. Mitigating strategies are in place.   
A hazard register (reviewed March 2013) is in place. Hazards and control plans are in place for care services, kitchen, laundry and external areas. All identified hazards have risk management strategies, such as minimisation, isolation or elimination. A hazard reporting process is in place and an annual hazard log is maintained.

D19.3: There is an H&S and risk management programme in place including policies to guide practice.

D19.2g; Falls prevention strategies are in place that includes 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, sensor mats, good fitting footwear, ultra-low beds and “crash” pads. Risk re-assessments are completed and physio referrals initiated.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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: There is an incident policy and monthly tracking that is taken to staff, quality and health and safety meetings. A monthly summary sheet of adverse events includes a detailed breakdown of incidents and accidents (eg, falls, absconding, behaviours, pressure areas, and medication error and skin tears). A record of the incident is recorded in the resident progress notes. In 18 of 18 incident/accident forms evidence next of kin have been notified. The RN is involved in clinical assessment for all incidents. There are documented actions and preventative or corrective actions completed on the incident/accident form. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.

##### **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:**

Current copies of practising certificates are held for the registered nurses, enrolled nurses, GPs and other allied health professionals involved in the delivery of clinical services.   
Seven staff files were randomly selected for review (quality co-ordinator/human resources manager, acting clinical services manager, one registered nurse, two HCAs, weekend cook and activity co-ordinator).

Qualifications of applicants are validated and police vetting is completed prior to appointment. Staff undergo a generic orientation including health and safety, fire training and infection control education. Staff also complete a specific orientation to their role. All seven files evidence completed orientation records. There is a four week orientation review, 11th week performance appraisal and annually thereafter. There is an improvement required around signed job descriptions and performance appraisal.

The organisation has an annual education programme with multiple sessions held every month. The quality co-coordinator, clinical services manager, manager, registered nurses, physiotherapist and external educators provide education and training for staff. The education programme includes mandatory training and clinical in-service relevant to the care of the residents such as dementia care, wound care, palliative care, pain management, continence management, restraint minimisation, loss and grief and pressure area management. The enrolled nurse is the service career force assessor. Managers attend district health board forums, NZ aged care association branch meetings and other education relevant to the role. The quality co-ordinator has completed InterRAI training. RNs are supported to attend knowledge and skills based education. RNs and the activity co-ordinator have a current first aid certificate.

Five of six HCAs working within the dementia unit have completed their NZQA dementia certificates. One of six staff (employed for three months) is to commence dementia NZQA dementia units within the next three months.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Qualifications of applicants are validated and police vetting is completed prior to appointment. Staff undergo a generic orientation including health and safety, fire training and infection control education. Staff also complete a specific orientation to their role. All seven files evidence completed orientation records. There is a four week orientation review, 11th week performance appraisal and annually thereafter.

**Finding:**

Three of seven staff files did not contain a signed job description. One of seven files did not have an 11th week performance appraisal completed. One of seven files did not evidence an annual performance appraisal.

**Corrective Action:**

Ensure employment policies and processes are followed.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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 in place. Staffing requirements are influenced by client dependency, staff qualifications, experience, skill, familiarity and mix.

The CEO reports the staff is stable with low turnover. A permanent clinical services manager has been appointed and commences employment on 21 July 2014. There are no current vacancies. The acting clinical services manager (RN) is employed full-time Monday to Friday. There is one RN on duty 24/7. An enrolled nurse is employed on the morning shift Monday to Friday. There is one HCA in the dementia unit 24/7. There are three HCAs on the full morning shift and one from 7-11am. There are three HCAs on the full afternoon shift and one from 5-9pm. The night shift is staffed in the rest home/hospital with one registered nurses and one HCA.

##### **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.)*

#### Standard 1.2.9: Consumer Information Management Systems **(**HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

**Attainment and Risk:** FA

**Evidence:**

Beetham provides hospital, dementia and rest home level care and the resident files are appropriate to the service type. Initial information (including a support plan) is recorded within 24 hours of entry, sufficient information is collected to manage resident needs. Resident files are integrated and include GP assessment and reviews; there is evidence of external health professional involvement where relevant. Care plans and notes are legible and where necessary signed (and dated) by RN. Entry in progress notes are dated, timed and record the name and designation of the staff completing the entry. The resident identifier is on the progress reporting sheet. Clinical files are kept in the nurses’ station with access only to those allied health professionals involved in the care of the resident. Archived records are stored in a locked area.

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry all potential residents have a needs assessment, completed by the needs assessment and co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family/whanau are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. Three residents (two rest home and one hospital) and six family/whanau (two rest home, three hospital and one dementia care) confirm they had received all relevant information prior to or on admission.  
E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:   
1. Minimising restraint.  
2. Behaviour management.  
3. Complaint policy.  
D13.3; The admission agreement reviewed aligns with a) -k) of the ARC contract.  
D14.1; Exclusions from the service are included in the admission agreement.  
D14.2; The information provided at entry includes examples of how services can be accessed that are not included in the agreement.  
E3.1; Two files were reviewed and both include a needs assessment as requiring specialist dementia care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.2: Declining Referral/Entry To Services **(**HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The admission policy describes the declined entry to services process. Beetham Health Care records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency. There are no declined entries recorded.

##### **Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)**

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy and process that describe resident’s admission and assessment procedures.   
D16.2, 3, 4. A registered nurse undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term care plan is developed in the eight of eight resident files sampled (four hospital, two rest home, two dementia) at Beetham Healthcare. In eight of eight resident files sampled the initial admission assessment and initial care plan summary were completed and signed off by a registered nurse. The resident assessment is carried out on admission and reviewed six monthly or earlier if resident health status changes. These are completed by the registered nurse (RN) with input from healthcare assistants (HCAs), the activities co-ordinators, family/whanau and any other relevant person. There is evidence of resident and/or family/whanau/EPOA involvement in the care planning process. Activity assessments and the activity care plans have been completed by the activity coordinators.

Care plans are used by nursing staff and HCAs to ensure care delivery meets the residents assessed needs. There is a verbal and written handover sheet for HCAs and registered nurses at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Progress notes are completed by the RNs and HCAs each shift. All eight resident files our sampled identified integration of allied health including general practitioner, geriatrician, mental health services for the older person and physiotherapist.

Medical assessments are completed within 48 hours of admission by the general practitioner (GP) in eight of eight resident files sampled. Residents retain their own GP. The GP interviewed visits weekly and is available by phone or fax communication for RN resident concerns. The afterhours GP roster is shared by the local GPs until 8pm then calls are referred to the hospital overnight. The GP states requests for afterhour’s visits are appropriate and timely.

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

Tracer methodology: rest home resident : *XXXXXX This information has been deleted as it is specific to the health care of a resident.*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Admission documentation obtained on interview with resident/family/whanau or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activity preferences, spiritual, cultural and social needs. Information on discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies are gathered by the Registered Nurse (RN) to develop the initial assessment and the first resident care plan within the required timeframes. All resident files sampled evidenced an initial assessment and care plan with reference to the information gathered on admission. Family/whanau (three hospital, two rest home and one dementia care) and residents (two rest home and one hospital) interviewed confirmed they had input into the resident assessments.

A range of assessment tools are completed on admission if applicable including (but not limited to): a) continence and bowel, b) coombes fall assessment, c) Norton scale pressure area assessment, d) nutrition and dietary preferences, e) pain scale and pain monitoring chart f) restraint/enabler assessment, g) wound assessment h) behaviour management (as applicable).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

An initial assessment form forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term care plan from information gathered over the first three weeks of admission. There is evidence of a holistic approach to care planning with resident and family/whanau input ensuring a resident focussed approach to the whole process. Three of four Maori residents do not have an individual Maori assessment and health care plan. Other allied health care professionals providing input such as physiotherapy, dietitian, and podiatrist are involved in the evaluations.

The integrated resident file also contains admission documents, informed consent forms, care documents, risk assessment tools and reviews, medical documentation, test results (laboratory and radiology), allied health notes, referrals and other relevant health information, associated assessments such as activities, behavioural, recordings weight, blood pressure, incident and accident and any other correspondence. Short term care plans are in place for short term needs. Six family/whanau advised on interview that they are involved in the development of the care plan and are kept well informed of changes to care or health status and support by staff is consistent with their expectations. Notes by GP and allied health professionals are evidenced. Family/whanau (three hospital, two rest home and one dementia care) interviewed are positive and complimentary about the staff, clinical and medical care provided. All are complimentary about the activities coordinators and the activities programme.

##### **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 Low

**Evidence:**

An initial assessment form forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term care plan from information gathered over the first three weeks of admission. There is evidence of a holistic approach to care planning with resident and family/whanau input ensuring a resident focussed approach to the whole process. The service has a Maori Health Plan in place that describes individual cultural assessments for Maori residents that guide staff in the delivery of culturally safe and acceptable care.

**Finding:**

Three out of four Maori residents do not have an individual Maori health plan as per policy.

**Corrective Action:**

Ensure Maori health plans are in place for Maori residents.

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service provides services for residents requiring rest home, hospital and dementia level of care at Beetham Healthcare Ltd. Individualised care plans are completed by the RN’s. When a resident condition alters, the RN initiates a review and if required, GP or specialist consultation. The three HCAs and two RN’s interviewed stated that they have all the equipment referred to in the long and short term care plans necessary to provide care, including hoists, electric beds, pressure relieving mattresses, cushions, tilting shower chairs, transfer belts, wheelchairs, gloves, aprons and masks.

D18.3 and 4; Dressings supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. Wound assessment plans include causative factors that may delay healing, type of wound, allergies, treatments, dressing frequency, intervention and evaluations are in place for eight wounds and three sacral pressure areas (all grade 1). Body maps show the location of the wound. The RN’s reviews wounds and records progress. Wound care advice is readily available to the RN’s. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day and night use. There are adequate supplies of continent products in all areas.

All falls are reported on the resident accident/incident form. Coombes fall risk assessments are completed on admission. There is evidence of physiotherapy referrals and involvement in resident assessments. The service contract a physiotherapist for two hours per week.

Resident’s weight is recorded on admission and monitored monthly. A wheel-on and chair scale is available. Seven of eight resident files evidence monthly weights. One rest home resident does not evidence a monthly weight from January 2013 to May 2014. There is an improvement required around weight management.

Pain monitoring using a pain scale tool is carried out for those on regular and prn pain relief.

There is an improvement required around documentation of interventions to reflect the resident’s current needs.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

**Finding:**

The following shortfalls were identified; (i) One rest home resident diagnosed with diabetes in February 2014 did not have a diabetes management plan in place or diabetic status linked to the long term care plan; (ii) One rest home resident does not evidence a monthly weight from January 2013 to May 2014 and the same resident has had weight loss; There is no evidence of weekly weighs as per the short term care plan; (iii) Risks associated with the use of enablers are not documented in the care plan of three out of three resident files sampled who use enablers; (iv) Two of two dementia care resident files sampled do not have individualised 24 hour behaviour management plans that include alternative strategies and activities for the de-escalation of behaviours.

**Corrective Action:**

Ensure interventions are documented to reflect the resident’s current needs.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are two activity coordinators employed 17.5-20 hours Monday to Friday to cover Beetham Healthcare facility. One activity coordinator has been employed three years, and the other three months and is currently working with career force to complete the diversional therapy training. The activity coordinators complete a monthly programme for rest home/hospital and dementia unit based on the resident’s interests. The residents enjoy crafts, bowls, games, baking, housie, (bodies in motion) exercise groups, walks, quizzes, and reminiscing, woodwork and Māori speaking sessions. One on one time is spent with the dementia residents. The programme is flexible to meet the recreational preferences of the residents. Outings are scheduled using a pre-book bus service (Sunshine bus). Residents are invited to all activities and functions. Entertainers and college/school children visit. Resident’s spiritual needs are met with inter-denominational church services weekly. Volunteers are actively involved weekdays and weekends. Resident meetings are held monthly where residents provide feedback and suggestions on the programme. Residents and family/whanau interviewed are satisfied with the content and variety of the activity programme. There is an activity assessment for each new resident from which an activity plan is developed. This is evaluated and reviewed every six months. There are activity plans in place for the dementia care unit residents.

D16.5d: There is a schedule in place to co-ordinate the review of all the individual activity plans at the time of residents long term care plan review and this is completed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

All initial assessments and initial care plans are developed by an RN within 48 hours of admission. The long term care plan is developed within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly review by GP. There is evidence of six monthly reviews and evaluation of long term care plans in seven of eight resident files which are signed by the RN. One resident has been in the service less than six months.

Care plan reviews are signed as completed by an RN. Short term care plans are developed for the management of short term needs. Five of eight short term care plans (two hospital, two rest home and one dementia) sighted in resident files have not been evaluated or closed off as resolved. Evaluation of short term care plans and review of risk assessments is an area for improvement.

D16.4a; Care plans are evaluated six monthly or more frequently when clinically indicated. ARC D16.3c; All initial care plans were evaluated by the RN within three weeks of admission.

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

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

**Attainment and Risk:** PA Low

**Evidence:.**

**Finding:**

(i)Risk assessments have not been reviewed six monthly as part of the care plan review process for continence (two hospital, one rest home), pain (three hospital and one rest home), pressure area (one hospital and one rest home) and falls (one hospital and one rest home). (ii) Five of eight short term care plans (two hospital, two rest home and one dementia) sighted in resident files have not been evaluated or closed off as resolved.

**Corrective Action:**

(i) Ensure risk assessments are reviewed at least six monthly or more frequently as required. (ii) Ensure short term care plans are evaluated within a timely manner

**Timeframe (days):** 90 *(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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The RN described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, speech language therapist and physiotherapist.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy is contracted to provide robotic roll medication. The nightshift RN checks the rolls when delivered. Any discrepancies are fed back to the pharmacy. One alternative medication used needs to be recorded on the medication chart. Medication trolleys are kept in locked treatment room in the rest home/hospital. There is a designated medication fridge. Temperatures are monitored and are within the acceptable range. All opened eye drops/ointments are dated on opening. Medication returns are kept in locked areas. There are no self-medicating residents. Controlled drug (CD) safes are kept within locked areas. There is weekly CD physical check evidenced in the controlled drug register signed by the RN and the pharmacy. RNs and designated HCAs complete annual medication competencies and medication education. Sixteen medication charts sampled (eight hospital, four rest home and four dementia) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. Five of 16 medication charts evidenced GP review three monthly and 11 charts had been recently re-written and not due for a three monthly review. There is an improvement required around medication documentation.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Staff are aware of their responsibilities in relation to drug errors. The self-administration of medication at Beetham does not occur. All residents' allergies are noted and residents are identified by photographs. 16 of 16 medication charts reviewed, all residents have up to date photographs for identification and those with allergies are identified. Medicine reconciliation is undertaken by the Registered Nurse when the new robotic rolls are delivered each month or as medications change. RN’s, enrolled nurses and caregivers administer medications.

**Finding:**

(i)One CD regular medication signing chart written on PRN signing chart and signed by one medication competent person (not a RN). (ii) Alternative medication used is not recorded on one of 16 medication charts. (iii) There is no medication error report written for one incorrect dose of controlled drug.

**Corrective Action:**

(i) Ensure that all controlled drug regular medications are charted on the regular medications signing chart and countersigned where an RN is not administering the controlled drug; (ii) Ensure alternative medications used are recorded on the medication chart.; (iii) Ensure medication errors are reported;

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are food policies/procedures for food services and menu planning appropriate for this type of service. There is a qualified chef who oversees food services, ordering of food items and staffing. The menu is a five week rotating summer and winter. This is reviewed by a qualified dietitian two yearly, reporting back any recommendations actioned. The RN provides the chef with a resident’s dietary profile on admission and informs the chef if there are any dietary changes. Resident likes and dislikes are known with alternative choices offered. Dietary needs included soft/pureed, vegetarian, high calorific and diabetic. There are specialised lip plates and utensils as required to promote resident independence at meal times. The main meal is at midday. Meals are served from hot boxes. The hot food temperature monitoring is carried out on the main meal. The kitchen is well equipped with adequate pantry and dry good storage space. A nutrition assessment is undertaken for each resident on admission. This includes likes and dislikes and special dietary requirements.

Eight out of eight resident files contained the nutrition assessment in line with the care plan review. Copies are provided to the chef, special diets including dislikes are written on the kitchen board for quick reference. Additional foods are supplied to the dementia unit fridge ensuring 24 hour availability of nutritional snacks for the residents. Plentiful amounts of fluids were sighted in all areas, and staff are observed assisting residents with drinks. Each resident had a fluid jug in their bedroom. The kitchen holds at least three days of food in case of an emergency. Fridge and freezer temperatures are recorded daily and all perishable goods in the fridge are date labelled. Staff are observed wearing correct protective wear, hats, aprons and gloves. There are cleaning schedules in place. Ecolab provide the chemicals, safety data sheets and provide chemical safety training as required. Chemicals are stored safely in the kitchen. All staff have received food safety and hygiene training. The chef has completed HSI (167) and (168) training within the last two years, and all staff has completed the unit standard 167. Six family/whanau (three hospital, two rest home, one dementia care) and three residents interviewed expressed satisfaction with food services.

Meals are delivered to the serviced apartments (as required) in hot boxes. There is a small communal dining area and kitchenette. The serviced apartments also contain a dining area for residents who wish to dine in their rooms. No change or improvement is required around meal service to the serviced apartments for rest home level of care residents.

E3.3f; There is evidence of additional nutritious snacks available over 24 hours.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

#### Standard 1.4.1: Management Of Waste And Hazardous Substances **(**HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

**Attainment and Risk:** FA

**Evidence:**

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Safety data sheets are readily available. Chemicals are stored safely throughout the facility. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff attended chemical safety May 2014.

##### **Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)**

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

**Attainment and Risk:** 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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.2: 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:**

The Beetham Healthcare building holds a current certificate of compliance (warrant of fitness) which expires on 9 July 2014. Beetham is a large purpose built single storey building built in 2011. There is safe internal access between the bedrooms and community areas. The facility has a large designated activity area, which is also used as a chapel, and a designated physiotherapy room with appropriate equipment. All bedrooms come complete fully furnished with flat screen TV, and internet connection. Electrical equipment has been checked and tagged. The external areas are well maintained with attractive gardens. There is a maintenance person employed for 15 hours per week. Staff report repairs and maintenance required in a maintenance book. The maintenance person follows a planned maintenance schedule that covers internal and external maintenance such as cleaning, equipment checks, emergency lights and gardens. Resident hot water temperatures are checked monthly with corrective actions carried out by the preferred plumbers.

ARC D15.3; There is adequate equipment available for the rest home, hospital and dementia unit. Interviews with two RN’s and three caregivers confirm there is adequate equipment including hoists, wheelchair scales and pressure area resources. Clinical equipment has been calibrated. Hoists have functional checks.

E3.4d; the lounge area is designed so that space and seating arrangements provide for individual and group activities.

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

E3.3e, E3.3c; There is a safe and secure outside area that is easy to access for dementia residents.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms come with full en-suite facilities. There is safe flooring, seating and hand rails appropriately placed in the shower rooms. Fixtures, fitting and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There are privacy locks on the doors. Residents interviewed confirmed that staff provides the resident with privacy when attending to personal needs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.4: Personal Space/Bed Areas **(**HDS(C)S.2008:1.4.4)

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

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

**Attainment and Risk:** FA

**Evidence:**

All bedrooms in the facility have electric beds. The rooms are uncluttered and contain items of resident’s personal property. Residents and family/whanau are encouraged to personalise their bedrooms. On the day of the audit, it was observed that walking frames, hoists and other required equipment can be manoeuvred around the residents’ personal space. Residents can be safely transferred onto their beds using a hoist. Residents are observed manoeuvring walking frames in rooms safely. Family/whanau interviewed confirms their bedrooms are of adequate size and they can personalise them as they like.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining **(**HDS(C)S.2008:1.4.5)

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Beetham Healthcare has separate lounges for each wing (hospital/rest home and dementia). The main lounges and dining areas are large and spacious. Communal areas are accessible and accommodates the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents are seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.

E3.4b; There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The dementia wing has quiet seating areas and a combined lounge/dining room.

D15.3d; Seating and space is arranged to allow both individual and group activities to occur.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

**Attainment and Risk:** FA

**Evidence:**

There is a laundry and cleaning manual that describes laundry and cleaning processes. There is a well-designed laundry with defined clean and dirty flow that ensures laundry is managed according to standards and guidelines at Beetham Healthcare. Resident’s laundry is laundered on site. Protective clothing is available including gloves, disposable aprons and masks. Chemicals are stored in a locked room in the laundry. Chemical are supplied by Ecolab who provide wall charts, conduct quality control checks and training as required. All chemicals are labelled correctly. On a tour of the facility, the floors were noted to be clean and free from stains. All bedrooms, hallways and communal areas are clean and tidy in appearance. Relatives (three hospital, two rest home and one dementia care) expressed satisfaction with the cleaning and laundry services.

##### **Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)**

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

**Attainment and Risk:** 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 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documented systems are in place for essential, emergency and security services. Policy and procedures document service provider/contractor identification requirements appropriate to the consumer group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors. The Beetham Health Care emergency plan has been finalised 20 March 2014 and signed off by the district health board (sighted).

Letters from New Zealand Fire Service reviewed dated 1 September 2011 advising approval of fire evacuation schemes. The last trial evacuation and fire safety training was held March 2014. Staff interviews and review of files provides evidence of current training in relevant areas. There is a designated staff member trained in first aid on each shift. Emergency and security situation education is provided to service providers during their orientation phase and at appropriate intervals. There are emergency “flip charts” with information in relation to emergency and security situations readily available/displayed for service providers displayed in staff areas.

A visual inspection of the facility evidences: emergency lighting, torches, extra food supplies, emergency water supply (external tank) and civil defence bin (checked two monthly). There is alternative cooking available (barbeque).

An appropriate call bell system that is easily used by the consumer or service provider to summon assistance if required and is appropriate to the resident group and setting, e.g. call bell system. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, ensuite toilet/showers, lounges and dining rooms. Residents interviewed confirm they have a call bell system in place which is accessible and staff respond to call bells in a timely manner.

The serviced apartment building has a call bell system in place that is connected to the rest home/hospital facility. The fire system is connected to the rest home/hospital facility.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** 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 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

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

**Attainment and Risk:** 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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All bedrooms and communal areas have large windows allowing adequate natural light. Rooms are well ventilated and windows provide natural light. There is adequate heating in all bedrooms and communal rooms. Residents and family interviewed stated the temperature of the facility is comfortable.

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

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

**Attainment and Risk:** 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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

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

**Attainment and Risk:** 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 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint minimisation and safe practice policies and procedures are in place. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. A registered nurse is the restraint co-ordinator and has defined responsibilities documented in a job description. The restraint co-ordinator attended a de-escalation study day at the district health board. Restraint minimisation and safe practice training is included in the induction programme and in-service education programme and includes staff completing a competency questionnaire. Restraint education and information hand-out was provided by the restraint co-ordinator in June 2014.   
Enablers are voluntary and the least restrictive option. Thirteen residents (11 hospital and two rest home) are using enablers (13 bedrails and three lap belts).   
Three files of residents using an enabler was selected for review. There is evidence of an assessment for the use of the enabler, voluntary, written consent was provided by the resident and the use of this enabler is linked to the resident’s care plan. The GP signs the resident consent form. All enabler use is reviewed six monthly by the approval group (restraint co-ordinator, clinical services manager, and quality co-ordinator). Risks associated with the use of enablers are not included in the care plan of three of three of the resident files viewed (link 1.3.6.1).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. There is an established and implemented infection control programme and internal audits that are linked into the risk management system. The infection control team and the governing body are responsible for the development of the infection control programme and its review.  
The infection control coordinator role is currently vacant awaiting the appointment of a clinical services manager (21 July 2014). The acting clinical services manager is currently fulfilling the infection co-ordinator role. There is a newly formed (June 2014) infection control team that includes the quality co-ordinator, infection control co-ordinator/clinical services manager, a kitchen hand and cleaner who meet monthly. The infection control co-ordinator provides a monthly report to the team and all staff that includes infection control statistics, trends and quality improvements. Staff interviewed (11) are well informed about infection control practises and reporting. Infection report forms are completed for all suspected infections. They can contact the RN or infection control co-ordinator if required and concerns can be written in progress notes and the communication book. For after hour’s requirements there is an RN on duty 24/7 and the infection control co-ordinator is available if required. Suspected infections are confirmed by GP visit, guidelines for infection and laboratory tests and results.

There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection.   
There is evidence (signage) of preventative measures in place to prevent resident exposure to infectious diseases such as Norovirus. An outbreak kit is readily available for use. The facility was in “lockdown” in December 2013 following Sapovirus outbreak. There is documented evidence of notification to the governing body, district health board and health protection unit. Outbreak management policies and procedures implemented minimised the risk of the spread of infection.

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

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

**Attainment and Risk:** 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 3.1.3 (HDS(IPC)S.2008:3.1.3)**

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

**Attainment and Risk:** 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 3.1.9 (HDS(IPC)S.2008:3.1.9)**

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

**Attainment and Risk:** 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 3.2: Implementing the infection control programme **(**HDS(IPC)S.2008:3.2)

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control criteria policy states the infection control co-ordinator and infection control team work in liaison with the staff across all services. Infection control team meetings have recently commenced (June 2014) and are combined with the health and safety representatives (meeting minutes for June 2014) sighted. The infection control co-ordinator (acting) and team have access to the infection control officer at the district health board (DHB), medical officer of health, laboratory services and GPs and external infection control consultant. There are monthly infection control link nurse meetings held at the DHB that are open to aged care providers.

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

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

**Attainment and Risk:** 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 3.3: Policies and procedures **(**HDS(IPC)S.2008:3.3)

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control policies and procedures are developed and reviewed by an external infection control specialist. The manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff.   
Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) documentation of suspected and actual infections, j) isolation, k) outbreak procedure, and l) notification of diseases.  
There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job descriptions, notification of diseases and educational hand-outs.

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

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

**Attainment and Risk:** 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 3.4: Education **(**HDS(IPC)S.2008:3.4)

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The acting clinical services manager (infection control co-ordinator) has maintained her skills and knowledge of infection control practice through previous attendance at an external infection control study day prior to employment at Beetham health care. The infection control officer at the DHB provides annual staff education last January 2014. Staff receive infection control education on orientation. Infection control is a set agenda item at the staff meetings and topical education is provided as required. Staff meeting minutes sighted. Consumer education occurs as required for example in regards to the influenza vaccine prior to written consent.

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

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

**Attainment and Risk:** 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 3.4.5 (HDS(IPC)S.2008:3.4.5)**

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

**Attainment and Risk:** 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 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 and quality co-ordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.  
Internal infection control audits (hand hygiene, cleaning, food services and laundry) also assist the service in evaluating infection control needs. There is close liaison with the GP's and infection control officer at the DHB that advise and provide feedback /information to the service. The GP and the service monitor the use of antibiotics through three monthly reviews and resident infections. Infection control data is collated monthly and reported to the monthly infection control team meeting.

All infections are documented on the infection monthly on line register including analysis and trends identified. The surveillance of infection data assists in evaluating compliance with infection control practices and identifies any areas for improvement. Quality improvement initiatives are recorded as part of continuous improvement.  
The staff are kept informed regarding infections, trends, corrective actions and outcomes as sighted in 2014 staff meeting minutes.

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