# Bupa Care Services NZ Limited - Hillsborough Hospital

## Current Status: 22 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

Hillsborough hospital is part of the Bupa group. The service provides hospital (geriatric and medical) level care for up to 47 residents. On the day of the audit, there were 46 residents.

There are established systems, processes, policies and procedures that are structured to provide appropriate safe quality care for the people in their care. Hillsborough continues to have a comprehensive quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team.

Hillsborough has an experienced Care Home Manager (Registered Nurse) that has been in the role for the last 18 months. A new manager has recently commenced and is currently completing orientation with the current manager. The manager is supported by a clinical manager and the Bupa Operations Manager.

The service is commended for achieving two continued improvement (CI) criteria ratings related to; organisational and service-level implementation an ongoing review of quality goals/benchmarking/governance, and implementation of quality and risk management system.

This audit identified two improvements required around aspects of care planning and medication documentation.

## Audit Summary as at 22 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 22 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. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 22 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 22 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 low risk. |

### Safe and Appropriate Environment as at 22 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 22 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 22 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 22 July 2014

### Consumer Rights

Hillsborough endeavours to provide care in a way that focuses on the individual residents' quality of life. Residents and relatives overall spoke positively about care provided at Hillsborough. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented; complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### Organisational Management

Hillsborough has a well-established Bupa quality and risk management system. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. An improvement is required around follow up of quality data collected. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Hillsborough is benchmarked in one of these (hospital). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff input into rostering.

### Continuum of Service Delivery

There is a comprehensive admission pack provided on entry to the service. All residents have a needs assessment prior to admission. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the long term support plan to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. An improvement is required around the documentation of interventions to reflect the resident’s current needs and weight recordings.

The activity co-ordinator implements the hospital activity programme to meets the individual needs, preferences and abilities of the residents. One on one time is spent with individual residents. Community links are maintained. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the GP. There is an improvement required around aspects of medication documentation.

All baking and meals are prepared and cooked on-site. Residents' food preferences and dietary requirements are identified at admission. This includes consideration of any particular dietary preferences or needs.

### Safe and Appropriate Environment

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with the majority of room with ensuites. There is wheelchair access to all areas. External areas are safe and well maintained. There is a spacious lounge and dining area and smaller lounges available within the facility for quieter activities or visitors. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has ceiling heating in the communal areas and panel heating in the bedrooms.

### Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has three residents on the register with an enabler in the form of bedrails and one resident in the hospital assessed as using a restraint. A register is completed that includes a three-monthly evaluation. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

### Infection Prevention and Control

The infection control (IC) programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

# 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:** | Bupa Care Services NZ Limited |
| **Certificate name:** | Bupa Care Services NZ Limited - Hillsborough Hospital |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Hillsborough Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric) | | | |
| **Dates of audit:** | **Start date:** | 22 July 2014 | **End date:** | 23 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:** | 46 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 5 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 10 | Total audit hours | 34 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 12 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 54 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | 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 Thursday, 21 August 2014

## **Executive Summary of Audit**

**General Overview**

Hillsborough hospital is part of the Bupa group. The service provides hospital (geriatric and medical) level care for up to 47 residents. On the day of the audit, there were 46 residents including one respite resident.

There are established systems, processes, policies and procedures that are structured to provide appropriate safe quality care for the people in their care. Hillsborough continues to have a comprehensive quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team.

Hillsborough has an experienced Care Home manager , a registered nurse (RN), that has been in the role for the last 18 months. A new manager has recently commenced and is currently completing orientation with the current manager. The manager is supported by a clinical manager and Bupa Operations Manager.

The service is commended for achieving two continued improvement (CI) ratings related to; organisational and service-level implementation an ongoing review of quality goals/benchmarking/governance, and implementation of quality and risk management system.

This audit identified two improvements required around aspects of care planning and medication documentation.

**Outcome 1.1: Consumer Rights**

Hillsborough endeavours to provide care in a way that focuses on the individual residents' quality of life. Residents and relatives overall spoke positively about care provided at Hillsborough. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented; complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community

**Outcome 1.2: Organisational Management**

Hillsborough has a well-established the Bupa quality and risk management system. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. An improvement is required around follow up of quality data collected. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Hillsborough is benchmarked in one of these (hospital).   
There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff input into rostering.

**Outcome 1.3: Continuum of Service Delivery**

There is a comprehensive admission pack provided on entry to the service. All residents have a needs assessment prior to admission. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the long term support plan to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family/whanau as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. An improvement is required around the documentation of interventions to reflect the resident’s current needs and weight recordings.   
The activity co-ordinator implements the hospital activity programme to meets the individual needs, preferences and abilities of the residents. One on one time is spent with individual residents. Community links are maintained. There are regular entertainers, outings, and celebrations.   
Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the GP. There is an improvement required around aspects of medication documentation.   
All baking and meals are prepared and cooked on-site. Residents' food preferences and dietary requirements are identified at admission. This includes consideration of any particular dietary preferences or needs.

**Outcome 1.4: Safe and Appropriate Environment**

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with the majority of room with ensuites. There is wheelchair access to all areas. External areas are safe and well maintained. There is a spacious lounge and dining area and smaller lounges available within the facility for quieter activities or visitors. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has ceiling heating in the communal areas and panel heating in the bedrooms.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has three residents on the register with an enabler in the form of bedrails and one resident in the hospital assessed as using a restraint. A register is completed that includes a three-monthly evaluation. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

**Outcome 3: Infection Prevention and Control**

The infection control (IC) programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 2 | 97 | 0 | 2 | 0 | 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 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | (i) There is no short term care plan in place for XXXXX for one resident. A XXXXX for another resident is not linked to the care summary. The dressing frequency for XXXXX area does not align with the dressing frequency on the wound evaluation form (however documentation does reflect the wound is improving and being managed). (ii) There is no documented XXXX management plan for an XXXXX resident. (iii) There is no documented specific dementia needs for resident altered behaviours. (iv) There are no monthly weight recordings for one resident XXXXX. There is no twice monthly weight monitoring in place as per evaluation for a resident at risk of malnutrition. | Ensure interventions are documented and implemented to reflect the resident’s current needs | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | 1) Five out of 14 medications charts did not have an indication for use of PRN medication (tramadol, XXXX, XXXX XXXX, XXXX). 2) Dittos are used for the dose of controlled drug on the signing sheets of two of four residents on controlled drugs. | 1) Ensure PRN medications have an indication for use. 2) Ensure the signing of medication meets legislative requirements. | 30 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.2.1.1 | The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Bupa has robust quality and risk management systems implemented across its facilities. Hillsborough continues to implement Bupa annual goals and objectives. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits monthly and completes a report to the GM. Hillsborough is part of the Bupa northern region two which includes seven facilities. There is an annual national Bupa's manager’s conference. Hillsborough has monthly Quality and Risk Management meetings and includes progress to meeting their annual quality goals. Hillsborough completes quarterly progress reports on meeting their quality goals for the year. The Hillsborough quality goals for 2014 include (but not limited to); a) the Careerforce programme to be implemented, b) To ensure a robust and professional system is in place for the completion of staff performance appraisals, c) become more involved with the community at large, d) To review the activities programme monthly to ensure it is complaint with Bupa policy and consolidates person centred care. Feedback is obtained from the residents in regards to meeting quality goals relevant to residents at resident meetings and others are discussed and action planned with staff. Reports are forwarded to the Senior Quality Management Coordinator at Bupa. This provides evidence that the quality goals are a 'living document'. Other goals achieved during the last year include (but not limited to); they have developed a veggie garden to help supply the kitchen with fresh produce as well as planting fruit trees at the back of the building. Whilst in the front garden a large Gazebo has been bought so the residents are able to shelter from the sun whilst out in the garden. The resident’s satisfaction survey has improved over the 2012 by 7% and they are using the results to drive changes. Staff education has been reviewed as part of their annual goals for 2013 and career force has been implemented with 95% of staff enrolled since its initiation in February 2014. They have also implemented a system where the staff are nominated for education sessions which allows them to ensure that everyone are attending education as per policy. The Personal Best programme has been driven by the manager and they have 86% on Bronze, 70% on Silver and 68% on Gold. They have had a changeover of staff due to promotion within Bupa for the RN’s and some retirements which has lowered the stats, however the manager is working with the new staff so that they achieve their Personal Best in a timely manner. |
| HDS(C)S.2008 | Criterion 1.2.3.7 | A process to measure achievement against the quality and risk management plan is implemented. | CI | Quality action forms are utilised at Hillsborough to records actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented, results are then fed back to staff at appropriate forums, e.g. quality meeting, quality nurses meeting. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits monthly and completes a report to the GM. The Hillsborough quality/risk committee reports quarterly on progress to meeting the quality goals identified at Hillsborough and this is forwarded to the quality coordinator for Bupa. Three of the four 2013 quality goals have been achieved. One goal around reducing restraint use within Hillsborough from 14 to one, has come from instigating a restraint committee (to lead the other staff) and education. With trials of equipment such as perimeter guards which allow a resident who is asleep to recognise they are on the edge of the bed – evaluation identified that this was a huge success as restraints had dropped so significantly. The quality coordinator and clinical manager are proactive in reporting to staff via 'user friendly' memo's any concerns or actions required by staff to improve as a result of analysing quality data. Some of the quality action plans initiated at Hillsborough included a) management of medical records, b) review of cleaning hours, c) completion of I&A forms. Corrective action plans have also been established following resident satisfaction survey Sept 2013. This included (but not limited to); nurse call times, shared clothing, food service and improved activities. These were discussed and actioned through resident/relative meetings and identify increased satisfaction. |

# 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:**

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about ‘The Code’ at induction and through on going in-service training (Feb 2014 - 17 attended) and staff complete the code of rights competency questionnaires. Interviews with three caregivers and two registered nurses showed an understanding of the key principles of the code of rights

##### **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:**

D6, 2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. There are translators available for the two residents that do not speak English.  
On entry to the service, the care home manager or clinical manager discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available at reception. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.  
Interviews with six hospital residents identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.  
Interviews with four relatives confirmed they are informed of the code of rights

##### **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:**

During the tour of the facility, respect for privacy and personal space was demonstrated. Resident files are held in the locked nurses’ offices. Interview with caregivers could explain ways resident privacy is maintained. Interviews with six residents confirmed that privacy is ensured.   
The September 2013 resident satisfaction survey identified that 91% resident has stated privacy was either excellent or good.   
Resident information includes Bupa vision and values. Residents and relatives interviewed were positive about the service in respect of considering and being responsive to meeting values and beliefs.   
D4.1a Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery (confirmed interview). An initial care planning meeting six weeks after admission is carried out, whereby the resident/family are invited to be involved - cultural/religious would be again considered at this time. Interviews with two residents confirmed that cultural beliefs and values were respected by staff. There are a multi-cultured staff at Hillsborough.  
Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, what to wear, getting up, meal times and meal alternatives) and that staff are obliging around choice.   
Care plans reviewed identified specific individual likes and dislikes. There is a question around 'choice' in the September 2013 resident satisfaction survey, 85% of residents stated excellent or good.   
A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training was last delivered in March 2014 and June 2014 (17 staff attended). Any incidents of alleged abuse are taken very seriously by management and staff.  
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. Person centred care/individuality and independence training is provided to staff annually.  
D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belongings 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 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)   
D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa’s facilities. The ADHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Local Iwi and contact details of tangata whenua are identified.   
Special events and occasions are celebrated at Hillsborough and this could be described by staff. There are two residents currently that identify as Maori. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process.   
Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member’s stay/care.

##### **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:**

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete ' the map of life'. Discussions with three relatives (including one Samoan) all identified that values and beliefs were considered. Discussion with six residents all stated they believed staff took into account their culture and values.  
D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment, planning process and interviews with residents confirmed that cultural values and beliefs were considered and discussed during review of the care plan.   
D4.1c Seven resident’s files were reviewed and all included the resident’s 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:**

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. There is policy to guide staff practice: Gift, Gratitude’s and Benefits, Delegations of Authority. Registered nurses meeting (monthly) includes any discussions on professional boundaries and concerns. The clinical manager (CM) also provides regular memo’s to registered nurses if there any concerns or reminders about responsibilities and code of conduct.

Advised that management provide guidelines and mentoring for specific situations. Interviews with three registered nurses, and the clinical manager described professional boundaries.

##### **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:**

Bupa provides a quarterly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company (described by RNs at Hillsborough). The Bupa geriatrician provides newsletters to GPs.   
Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Hillsborough is currently benchmarked in one area (hospital). A quality improvement programme is implemented that includes performance monitoring. Graphs and data is provided to Hillsborough staff on the noticeboard and corrective actions completed when trends are evident or areas are above the benchmark, i.e.: skin tears were above the benchmark June 2014. Corrective action plans have been established and evaluated for effectiveness.   
Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10.   
  
ARC A2.2 Services are provided at Hillsborough that adhere to the health & disability services standards. There is an established quality improvement programme that includes performance monitoring. Improvements have been noted in this area since the recent facility health check.  
ARC D1.3 all approved service standards are adhered to.   
A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.  
  
There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.  
  
There is a dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan (sighted with quality meeting minutes). Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation.   
ARC D17.7c There are implemented competencies for caregivers, enrolled nurses and registered nurses. Competencies are completed for key nursing skills at Hillsborough including (but not limited to); a) moving & handling, b) wound care, c) assessment tools and d) medication. RNs have access to external training.   
Discussions with residents and relatives at Hillsborough were overall positive about the care they receive.  
The management team at Hillsborough described the following quality initiatives implemented since previous audit.

(i)Monthly newsletter is published with information regarding events and changes within Hillsborough.

(ii) Relatives forum has been set up and several new innovations have come from these meetings – communication books for relatives to write in, in the residents room, a microwave for heating wheat bags in an area where the relatives don’t have to ask staff to do this, recycling bins for plastic and paper in communal areas, one place where relatives can look to see if there are any of their loved ones clothes which are missing there.

(iii) From the Residents Survey food service has been improved, the kitchen is serving the meals directly to a member of staff who then delivers it hot to the resident. Residents were asked about the improvement and suggested bread and butter on the tables, along with a glass of wine or beer and this has been instigated.

(iv) There is now a Men’s Shed area is being organised, so the men are able to do things which are more male orientated.

(v) A pictorial emergency folder for information, where photos of where to find equipment and valves and how to switch the power/gas off etc. copies in the nurses’ station/reception and maintenance shed.

(vi)The facility has faced a major change with the retirement of its manager of 25 years in early 2013. They have developed a veggie garden to help supply the kitchen with fresh produce as well as planting fruit trees at the back of the building. Whilst in the front garden a large Gazebo has been bought so the residents are able to shelter from the sun whilst out in the garden.

(vii) The 2013 resident’s satisfaction survey has improved over the 2012 by 7% and they are using the results to drive changes.

##### **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:**

Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.  
The clinical manager and two registered nurses interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for July 2014 identified that all 19 incident forms demonstrated that family were notified.  
  
As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was last completed in April 2014 at Hillsborough with a result of 94%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.   
D16.4b: The three relatives interviewed stated that they are always informed when their family members health status changes.   
  
There is a Bupa residents/relatives association that provides a strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. There is also a Bupa NZ communications manage. This person's role is to keep people informed and engaged about Bupa NZ’s strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.  
Interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and Government Agencies is available. In addition, there are a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available.

Staff and a relative interviewed how staff manage to communicate with two residents that don’t speak English. There are also staff available to interpret.  
D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry  
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.   
D11.3: The information pack is available in large print and advised that this can be read to residents

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

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

**Attainment and Risk:** 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 service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are procedure information sheets available including (but not limited to); a) minor skin surgery, b) catheterisation, and c) sub cut fluids. Completed resuscitation treatment plan forms were evident on all seven resident files reviewed. Where the resident is incompetent there is evidence of GP and family discussion regarding a clinically not indicated resuscitation status. General consent forms were evident on seven resident files reviewed. Discussions with three caregivers and three RNs confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. The Bupa care services resuscitation of resident’s policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The medical resuscitation treatment plan and resuscitation advance directive is completed as soon as possible after admission. All resuscitation treatment forms in the seven resident files are signed appropriately. The service is introducing advance care planning completed by the resident. One of seven files contained an advance care plan.

##### **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:**

Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with two registered nurses described how residents are informed about advocacy and support. Interviews with six residents confirmed that they are aware of their right to access advocacy.   
D4.1d; Discussion with three family identified that the service provides opportunities for the family/EPOA to be involved in decisions.   
ARC D4.1e, Seven resident files reviewed included information on resident’s 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:**

Visitors were observed coming and going during the audit. There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census.   
D3.1.e: Interviews with six residents confirmed that the activity staff help them access the community such as going shopping and visiting.

##### **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:** FA

**Evidence:**

The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'.  
There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented.   
Discussion with six residents and three relatives confirmed they were provided with information on complaints and complaints forms.   
2014 YTD complaints were reviewed and included 10 written complaints and three verbal complaints. All were well documented including investigation, follow up letter and resolution.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan.   
Hillsborough has set specific quality goals for 2014 including (but not limited to); a) the Careerforce programme to be implemented, b) To ensure a robust and professional system is in place for the completion of staff performance appraisals, c) become more involved with the community at large, d) To review the activities programme monthly to ensure it is complaint with Bupa policy and consolidates person centred care.

Bupa Hillsborough provides hospital level care for up to 47 residents. There were 46 residents (including one respite) on the day of audit. Under the medical component of their certification, there was one resident receiving palliative care and two LTCP contracts.  
  
The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Hillsborough is part of the northern (2) Bupa region which currently includes seven facilities. The managers in the region teleconference weekly. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Hillsborough and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on-going progress to meeting their goals. A forum is held every six months (with national conference including all the Bupa managers).   
  
The Bupa Way was launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa Way' has been provided to staff. Standardised Bupa assessment booklets and care plans are now fully established at Hillsborough.  
  
The organisation has a Clinical Governance group. The committee meets two monthly. The committee reviews the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Feedback is provided to managers at forums and also to staff through newsletters. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly. Feedback is provided to each facility (sighted).  
  
Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10.  
  
Hillsborough has an experienced Care Home manager (RN) that has been in the role for the last 18 months. A new manager has recently commenced and is currently completing orientation with the current manager (the current manager is moving on to manage another Bupa facility). The new manager has been with Bupa since January 2014 in a clinical manager position. She has many years’ experience in aged care manager. The manager is supported by an experienced aged care Clinical Manager (RN) that has been in the role for the last two years. There are job descriptions for both positions that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.  
ARC, D17.3di (hospital), the manager and clinical manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

**Attainment and Risk:** CI

**Evidence:**

The Bupa Way was launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa Way' has been provided to staff. Standardised Bupa assessment booklets and care plans are fully established at Hillsborough.  
  
The organisation has a Clinical Governance group. The committee meets two monthly. The committee reviews the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Feedback is provided to managers at forums and also to staff through newsletters. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly. Feedback is provided to each facility (sighted).  
  
Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10

**Finding:**

Bupa has robust quality and risk management systems implemented across its facilities. Hillsborough continues to implement Bupa annual goals and objectives. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits monthly and completes a report to the GM. Hillsborough is part of the Bupa northern region two which includes seven facilities. There is an annual national Bupa's manager’s conference. Hillsborough has monthly Quality and Risk Management meetings and includes progress to meeting their annual quality goals. Hillsborough completes quarterly progress reports on meeting their quality goals for the year. The Hillsborough quality goals for 2014 include (but not limited to); a) the Careerforce programme to be implemented, b) To ensure a robust and professional system is in place for the completion of staff performance appraisals, c) become more involved with the community at large, d) To review the activities programme monthly to ensure it is complaint with Bupa policy and consolidates person centred care. Feedback is obtained from the residents in regards to meeting quality goals relevant to residents at resident meetings and others are discussed and action planned with staff. Reports are forwarded to the Senior Quality Management Coordinator at Bupa. This provides evidence that the quality goals are a 'living document'. Other goals achieved during the last year include (but not limited to); they have developed a veggie garden to help supply the kitchen with fresh produce as well as planting fruit trees at the back of the building. Whilst in the front garden a large Gazebo has been bought so the residents are able to shelter from the sun whilst out in the garden. The resident’s satisfaction survey has improved over the 2012 by 7% and they are using the results to drive changes. Staff educationhas been reviewed as part of their annual goals for 2013 and career force has been implemented with 95% of staff enrolled since its initiation in February 2014. They have also implemented a system where the staff are nominated for education sessions which allows them to ensure that everyone are attending education as per policy. The Personal Best programme has been driven by the manager and they have 86% on Bronze, 70% on Silver and 68% on Gold. They have had a changeover of staff due to promotion within Bupa for the RN’s and some retirements which has lowered the stats, however the manager is working with the new staff so that they achieve their Personal Best in a timely manner.

**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, the clinical manager covers the manager’s role. The service is supported by the Bupa Operations Manager. 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.  
The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to residents that require hospital (medical) level care. There is a house GP that visits at least weekly or more frequently as required. There is a Physiotherapist two days per week reviewing mobilisation plans and abilities of Residents and assisting in training staff with Safe Manual Handling competencies.  
The service consults with the Bupa dementia leadership group, physiotherapist, dietitian, and mental health for older people.

##### **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:**

Hillsborough continues to have a comprehensive quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team.   
  
The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Bupa policies and procedures have been implemented throughout the year. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the Quality and Risk team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule.  
Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.  
  
Key components of the quality management system link to the monthly quality meeting at Hillsborough. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation.   
There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the resident data and staff incidents/accidents. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. There is a monthly IC committee at Hillsborough. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. Health and safety committee meets as part of the staff meeting and is also an agenda item at the quality committee.   
  
The service has established Corrective Action plans (CAP) where incidents/infections are above the benchmark. Audit summaries and action plans are completed where a noncompliance is identified. Memos are also provided to staff around corrective actions required; examples include (but not limited to): pain management 29/5/14, dressing changes 30/6/14.  
  
The service continues to collects data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.  
D19.3: There is a H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents.   
  
D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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:** CI

**Evidence:**

The service has maintained a continual improvement process around implementation of their quality and risk management programme since previous audit.

The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these.

Benchmarking reports are generated throughout the year to review performance over a 12 month period. A monthly summary of each facility within the Operations Managers region is also provided for the Ops Mgr which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Operations Managers monthly summaries)

Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. The quality coordinator writes a quality report which is presented too staff meetings. This includes feedback on audits.

**Finding:**

Quality action forms are utilised at Hillsborough to records actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented, results are then fed back to staff at appropriate forums, e.g. quality meeting, quality nurses meeting. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits monthly and completes a report to the GM. The Hillsborough quality/risk committee reports quarterly on progress to meeting the quality goals identified at Hillsborough and this is forwarded to the quality coordinator for Bupa. Three of the four 2013 quality goals have been achieved. One goal around reducing restraint use within Hillsborough from 14 to one, has come from instigating a restraint committee (to lead the other staff) and education. With trials of equipment such as perimeter guards which allow a resident who is asleep to recognise they are on the edge of the bed – evaluation identified that this was a huge success as restraints had dropped so significantly. The quality coordinator and clinical manager are proactive in reporting to staff via 'user friendly' memo's any concerns or actions required by staff to improve as a result of analysing quality data. Some of the quality action plans initiated at Hillsborough included a) management of medical records, b) review of cleaning hours, c) completion of I&A forms. Corrective action plans have also been established following resident satisfaction survey Sept 2013. This included (but not limited to); nurse call times, shared clothing, food service and improved activities. These were discussed and actioned through resident/relative meetings and identify increased satisfaction.

**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: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The competed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)".   
Incident forms reviewed for July 2014 identified that all 19 incident forms identified clinical follow up by a registered nurse/clinical manager and monitoring (such as neurological observations) having been undertaken when indicated.   
D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Quality indicator- corrective action plan was established for increased skin tears when they were above the benchmark in July, a toolbox talk was also provided with staff.  
   
Discussions with service management, overall confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Register of registered nurse (RN) and enrolled nurse (EN) practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).  
  
The service has implemented the Bupa orientation programme that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, RN four weeks), during this period, they do not carry a clinical load.   
Staff interviewed (three caregivers, three registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.   
There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (clinical manager, one registered nurse, three caregivers, activity therapist, and cook). All staff files included a personal file checklist that is maintained. Appraisals are up to date.  
  
Interviews with the manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures). 95% Caregivers are enrolled in Career Force and 19 are working through these modules, three staff members have finished all modules. Three caregivers and have commenced career force dementia modules.  
  
There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. delirium, dementia. Bupa is the first aged care provider to have a Council approved professional development recognition programme (PDRP). The nursing Council of NZ has approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. Four RNs have commenced their PDRP. Registered nurses at Hillsborough have taken on various roles as resource nurses (including ostomy nurse, diabetic nurse and palliative care nurse). As part of taking on these roles they have completed extra training at the DHB to undertake these resource roles at Hillsborough.  
  
Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place.   
A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.   
D17.7d: RN competencies include; assessment tools, Blood Sugar Levels /Insulin administration, Controlled Drug administration, moving & handling, nebuliser, oxygen admin, restraint, wound management, and subcutaneous fluids.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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 (359) that aligns with contractual requirements and includes skill mixes. The Bupa WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.  
The facility manager (RN) works Monday- Friday 40 hours per week and is available on call after hours.  
The clinical manager works Monday- Friday 40 hours per week.  
There is RN cover 24/7.  
A review of rosters evidenced adjustments to the roster to cover for staff sickness and annual leave.

While there has been resident feedback in complaints and meeting minutes about answering call bells, the management team completed call bell audits in June which ranged from 2mins to 30mins. Corrective actions were established as a result. This is being monitored closely by management.

Three caregivers and six residents interviewed overall stated staffing was satisfactory.

##### **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:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.  
Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked room or secure storage for unused files.  
All resident records contain the name of resident and the person completing.   
Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.   
D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name

##### **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:**

The service has a well-developed assessment process and resident’s needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service. Information gathered at admission is retained in resident’s records. Six hospital residents and three relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. Seven out of seven admission agreements viewed are signed.

D14.1 exclusions from the service are included in the admission agreement.

##### **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:**

There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry was declined.

##### **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:**

The service provides for hospital level of care. There is an admission, assessment and care planning policy.   
D.16.2, 3, 4: The seven hospital resident files sampled identified that the registered nurses (RN) complete an initial nursing assessment within 24 hours. Information gathered on admission from the needs assessment, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. Seven hospital files sampled (including one younger person and one resident under long term chronic condition) identified that the long term support plan is developed within three weeks. All seven long term care plans sampled are signed and dated by the primary RN. There is documented evidence families are invited to attend the initial care plan meeting and multidisciplinary care plan reviews and GP visits. Families unable to attend meetings have a copy of the care plan mailed to them for input. The activity co-ordinators complete an activity assessment, “Map of Life” and individual activity care plan (section two of the long term support plan) in consultation with the resident/family/whanau as appropriate.   
  
D16.5e: Seven of seven long term resident files sampled identified that the GP had seen the resident within two working days. It was noted in all long term resident files sampled that the GP has examined the resident three monthly and carried out a medication review. A GP stamp is used which states if the resident is stable. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. All resident files sampled identified integration of allied health professionals and a team approach including GP, physiotherapist, podiatrist, dietitian and speech language therapist   
There service contracts two GPs to provide medical services for the residents. The GP interviewed has a diploma in geriatric medicine. He has his own practice and visits the service weekly and more often as required for more urgent concerns. The GP is available 24/7 and employs a locum to cover for his leave. The RNs communicate by fax or phone. The GP stated that after hour calls are reduced due to RN clinical assessments and interventions being made within a timely manner. The GP liaises with the geriatricians and psychogeriatricans and response to referrals are within a reasonable timeframe.

Two RNs (interviewed) confirm there is a verbal handover and report book and written handover guide on each resident at the beginning of each shift for all staff (rest home and hospital). Staff are required to read short term care plans in place, progress notes and care summaries. A communication diary is in place. The three caregivers interviewed state the communication system is good and they receive relevant information at handover to deliver safe and timely cares for the residents.   
The geriatrician, hospice and mental health services are readily available as required.   
The service contracts a physiotherapist twice weekly. A physiotherapy assistant (employed) works 5.5 hours per day and carries out physiotherapy instructions for residents and exercise programmes. A podiatrist visits residents regularly.

Tracer methodology: Resident with challenging behaviours.

*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:**

Hillsborough hospital use the Bupa assessment booklets and lifestyle templates for all residents. The assessment booklet provides in-depth assessment tools including; falls, Braden pressure area, skin, mini nutritional, continence, pain, cultural assessment and dependency and activities assessments.   
Additional risk assessment tools include behaviour, restraint and wound assessments as applicable. Risk assessments are completed on admission and reviewed six monthly as part of the support plan review. A resident needs data is developed on admission.   
The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information. Needs outcomes and goals of consumers are identified.

##### **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:** FA

**Evidence:**

Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health.  
The long-term care plan is completed within three weeks in seven of seven resident files sampled. There is a long term lifestyle care plan that includes; a) hygiene, b) medical, c) skin and pressure area care, d) bladder and bowels, e) mobility, f) food and fluids, g) rest and sleep, h) communication, i) emotional well-being, j) spirituality, k) religion and culture, and l) activities. Lifestyle care plans demonstrate service integration.   
Long term residents' care plans reviewed on the day of the audit (seven hospital) provide evidence of individualised support, however there is an improvement required around the documentations of interventions (link 1.3.6.1.).   
Residents and family member interviewed confirm care delivery and support by staff is consistent with their expectations.   
D16.3k:, Short term care plans are in use for changes in health status. Short term care plans sighted in resident files are for vomiting, UTI, chest infection and weight loss following hospital admission.   
D16.3f: The seven resident files reviewed identified that the resident/family/whanau have the opportunity to be involved in the care planning process.

##### **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:** 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 1.3.5.3 (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 Low

**Evidence:**

Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including accident/incidents, infections, GP visits, appointments etc. Discussions with families are documented on the family contact form in the resident file.   
Three caregivers and two RNs interviewed state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists (checked May 14), two chair scales (calibrated May 14), transferring equipment, walking frames, wheelchairs, lazy boy chairs on wheels and gloves, masks and aprons.   
   
18.3 and 4: Adequate dressing supplies are available. Wound management policies and procedures are in place.   
Wound assessment, wound management and evaluation forms are in place for two skin tears, three leg ulcers, five minor wounds and one surgical wound. There are five sacral pressures. One is grade 4 and present on admission. Chronic wounds are linked to the care plan. Photos are taken of chronic and non-healing wounds. The GP is notified of any non-healing wounds as evidenced in the GP notes and chromic wounds are reviewed at the three monthly medical review. There are improvements required around aspects of wound documentation.

Continence products are available and resident files include and management a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. The clinical manager (interviewed) described the referral process should they require assistance from a wound specialist, continence nurse, dietitian, speech language therapist, diabetes nurse or other allied health or nursing specialists.   
  
There are a number of monitoring forms available for use that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, blood sugar monitoring, bowel records, continence diary, restraint monitoring and neurological observations.

There is an improvement required around the documentation of interventions to reflect the resident 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 Low

**Evidence:**

Wound assessment, wound management and evaluation forms are in place for two skin tears, three leg ulcers, five minor wounds and one surgical wound. There are five sacral pressures. One is grade 4 and present on admission. Chronic wounds are linked to the care plan. Photos are taken of chronic and non-healing wounds. The GP is notified of any non-healing wounds as evidenced in the GP notes and chromic wounds are reviewed at the three monthly medical review. Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There are a number of monitoring forms available for use that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, blood sugar monitoring, bowel records, continence diary, restraint monitoring and neurological observations.

**Finding:**

(i) There is no short term care plan in place for a sacral pressure area for one resident. A sacral pressure area for another resident is not linked to the care summary. The dressing frequency for a sacral pressure area does not align with the dressing frequency on the wound evaluation form (however documentation does reflect the pressure area is improving and being managed). (ii) There is no documented diabetic management plan for an insulin dependent diabetic resident. (iii) There is no documented specific dementia needs for resident altered behaviours. (iv) There are no monthly weight recordings for one resident between December 2013 and April 2014. There is no twice monthly weight monitoring in place as per evaluation for a resident at risk of malnutrition.

**Corrective Action:**

Ensure interventions are documented and implemented 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:**

The service employs an activity co-ordinator who work 32.5 hours per week each from Monday to Friday. The hospital activity co-ordinator has been in the role for five years, worked as a caregiver previously and has an aged care qualification and current first aid certificate. The hospital activity programme follows the Bupa core activities plan and is adapted for residents of lesser physical ability while also maintaining their recreational and social needs, interests, hobbies and community links. Weekly activities include a variety of exercises, bowls, housie, entertainment and community visitors. One on one time is spent with residents which includes hand care (massage/manicures), chats and discussions, reminisce and other individual activities as they desire. A recent quality initiative is a men’s shed which is currently being built. There is a large lounge where activities take place. Special occasions and events are celebrated such as ANZAC day where the residents made a wreath and a service held on-site. Community visitors include pet outreach (SPCA and St Johns), Chinese choir and other musical entertainers, Buddhist temple persons, and volunteers (two) who visit weekly to chat with residents. A trainee minister visits residents weekly. The local churches rotate to provide a church service on three Sundays of each month. There is a midweek weekly catholic service/communion.

Currently a mobile taxi service with a wheelchair hoist is hired monthly for outings with visits to garden centres, museums, drives to the beach and more recently a lunch outing to Snow Planet during the winter Olympics. The activity co-ordinator, physiotherapy assistant and family accompany residents on outings. Outings will be more frequent with the purchase of a new van (wheelchair hoist) that will be shared between another local Bupa facility.

Family are invited to attend the resident meetings chaired by the manager. This meeting provides an opportunity for feedback and suggestions on the programme, outings and entertainment. Six residents interviewed are happy with the choice and variety activities offered. If they choose not to participate in the activity the activity co-coordinator visits them for a chat and one on one activity time.   
All residents have an activity assessment, “Map of Life” and activity plan developed in consultation with the resident/family/whanau as appropriate. There is a co-ordinated approach to the review of the activity care plan (section 2 of the long term care plan) with the activity co-ordinator involved in the multidisciplinary review. Resident individual activity participation registers are maintained

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.4a Care plans are evaluated by the primary registered nurse six monthly or when changes to care occur as sighted in five of seven long term resident files sampled. Two residents have not been at the service long enough for a review. Short term care plans for short term needs are evaluated and either resolved or added to the long term care plan as an on-going problem. The multidisciplinary review involves the RN, GP and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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:**

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to dietitian, speech language therapist, vascular service, needs assessor, mental health services for the older person, geriatrician and hospital specialists.

D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care from rest home to hospital level of care.  
D 20.1 discussion with the clinical manager identified that the service has access to GPs, ambulance/ emergency services, allied health, dietitians, physiotherapy, continence and wound specialists.

##### **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:**

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. The yellow envelope system is used for transfers to the emergency department. A record of transfer documentation 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.

##### **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 Low

**Evidence:**

There is a locked medication room where two medication trolleys and pharmaceutical supplies are kept. The supplying pharmacy deliver the regular monthly robotic rolls and PRN medication (blister packs). A registered nurse on night shift and one other medication competent person check the medications on delivery as sighted on the robotic checking form. Any discrepancies are fed back to the supplying pharmacy. Returns are stored safely in the medication room until collected. All stock and expiry dates are checked. Emergency drugs, first aid kit, oxygen and suction is checked weekly. RNs and two senior caregivers who administer medications complete annual medication competency and education. RNs have completed syringe driver competency and annual refreshers. Standing orders are current. A verbal order for a controlled drug was taken by two RNs and signed on the medication chart by the GP within 24 hours (sighted). All eye drops in use in the medication trolleys are dated on opening. The medication fridge has temperatures recorded daily and these are within acceptable ranges. There are controlled drug checks weekly and end of page stocktake by two RNs. There is a pharmacy stocktake six monthly last completed June 2014. Controlled drugs are administered by RNs only.

Fourteen medication charts (seven rest home and seven hospital) are sampled. All have dated photo identification and allergy status noted. The medication charts are pharmacy generated. There is an improvement required around indications for use of PRN medications. All PRN medications administered are dated and timed. There is an improvement required around the signing of administration of medications.   
Fourteen of 14 medication charts have been reviewed three monthly by the GP.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Fourteen medication charts (seven rest home and seven hospital) are sampled. All have dated photo identification and allergy status noted. The medication charts are pharmacy generated. All PRN medications administered are dated and timed. Fourteen of 14 medication charts have been reviewed three monthly by the GP

**Finding:**

1) Five out of 14 medications charts did not have an indication for use of PRN medication (XXXX XXXX XXXXX) 2) Dittos are used for the dose of controlled drug on the signing sheets of two of four residents on controlled drugs.

**Corrective Action:**

1) Ensure PRN medications have an indication for use. 2) Ensure the signing of medication meets legislative requirements.

**Timeframe (days):** 30 *(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:**

Bupa policies and procedures are in place. The service employs a cook from 7am to 3pm. The cook is supported by morning kitchen hand and an afternoon kitchen hand to assist with evening meal. The national six weekly menus have been audited and approved by the company dietitian. Variations to the menu are recorded. All meals and baking is done on site. The residents have a nutritional record completed on admission which identifies dietary requirements, likes and dislikes. This is reviewed as part of the care plan review. A communication book is used between the staff. There is specialised crockery such as lip plates and mugs and utensils to promote resident independence with meals. Alternative choices are offered for dislikes and this is confirmed on resident interviews (six). Special diets are catered for including pureed and diabetic juices are provided for diabetics. Meals are served from a bain marie to the dining room. Staff are observed sitting and assisting/feeding residents in the dining room at lunchtime. End cooked food temperatures are checked and recorded for all foods. Fridge, freezer and chiller temperatures are recorded daily. All foods in the fridges and chiller are dated. Inwards good temperatures are recorded for all chilled/frozen foods. The dishwasher temperature is recorded daily. Staff are observed wearing appropriate protective clothing. Chemicals are stored safely. Cleaning duties list is maintained (sighted). The maintenance person undertakes cleaning duties such as walls and ceilings as per the three monthly and six monthly cleaning schedules (sighted).

There is a well equipped kitchen with a good work flow, separate dishwashing and food preparation/baking areas, external delivery area, walk-in freezers and chiller. Inwards goods are temperature checked on arrival. All foods in the chillers, refrigerators and freezer are date labelled. There is daily temperature monitoring of fridges and freezers within the kitchen and fridges within the facility. There is a locked chemical cupboard within the kitchen for the storage of chemicals. Staff are observed wearing appropriate personal protective clothing including hats, aprons and gloves.

Residents have the opportunity to provide feedback on the menu and food services through the resident meeting. Meeting minutes are available to the food services team.   
Food services staff have attended food safety and hygiene training and chemical safety training.

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

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

**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:**

There is a chemical/substance safety policy. There are policies on the following:- waste disposal policy - medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics. Procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer’s labels and stored in locked areas in all services. Safety data sheets and product sheets are available. A spills kit is in place. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. The maintenance person is a health and safety representative and has attended Stage 1 health and safety training and chemical safety training.

##### **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 building holds a current warrant of fitness which expires on 22 December 2014. The building has two levels with lift access between the floors. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a maintenance person employed for 20 hours a week at Hillsborough and available on call if required. Repairs and maintenance requests are entered into a log book that is checked daily and signed off as repairs are addressed (sighted). There is a 52 week planned maintenance programme in place. Hot water temperature is monitored weekly in resident areas and are within the acceptable range. Air temperatures in the main lounge are monitored. Preferred contractors have had a site induction completed. All medical equipment was calibrated June 2014.

The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents are observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.   
ARC D15.3, The following equipment is available, electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists (checked May 14), two chair scales and one wheel-on scale (calibrated May 14), transferring equipment, walking frames, wheelchairs, lazy boy chairs on wheels and gloves, masks and aprons.

##### **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 have ensuites with the exception of one wing. There are adequate communal toilets/showers available. There is appropriate signage with easy clean flooring and fixtures. Privacy locks indicate whether the toilet/shower is vacant or in use. There are communal toilets near the lounge, dining and activity areas. Six residents interviewed report their privacy is maintained at all times.

##### **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:**

The hospital bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment including hoists to safely deliver care. Six caregivers (interviewed) report that rooms have sufficient space to allow cares to take place. The doors are wide enough for ambulance trolley access. Residents are encouraged to personalise their bedrooms as sighted.

##### **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:**

There is a spacious central lounge and dining room in the hospital. Smaller lounges are available for small group or individual activities or for visitors. Tea and coffee making facilities are available. All communal areas are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this. The hospital dining room and lounges accommodate specialised lounge chairs.   
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 are policies including - cleaning department - use of equipment policy and a cleaning schedules in place. There is also a cleaning schedule/methods policy for cleaners. All linen and personal clothing is laundered on site. There is a dedicated laundry person Monday to Sunday from 7am to 4.30pm. The laundry is well equipped with a defined dirty and clean area and entry and exit doors. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles. Chemicals are stored safely and the laundry is locked after hours. Laundry staff have attended infection control in-service and chemical safety training. Laundry cleaning schedules are maintained. There is a laundry schedule for the laundering of hoist slings.

There are two cleaners on per day for 5.5 hours each. Cleaning trolleys are well equipped and stored in locked cleaners cupboards. Cleaning schedules are maintained. . The service has a vax machines for the cleaning of carpets. Cleaners have attended chemical safety.   
Personal protective equipment is available in the laundry, cleaning and sluice room. Staff are observed to be wearing appropriate protective wear. Six residents interviewed are happy with the laundry and cleaning services provided. The cleaning and laundry attend a monthly service meeting and receive feedback on the service from the resident/relative meeting. Satisfaction survey September 2013 identified that 93% were satisfied with laundry services and 98% satisfied with cleanliness.

##### **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:**

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety occurred in February 2014. Fire evacuations are held six monthly. A fire evacuation is held six monthly and the last fire safety training was provided Feb 2013.   
There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents’ details. There is an approved evacuation plan.  
The facility is well prepared for civil emergencies and has emergency lighting and BBQ’s. A store of emergency water is kept. Emergency food supplies sufficient for at least three days are available. Extra blankets are also available. The facility has civil defence kits.  
Hoists have battery back and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept.  
There is a store cupboard of supplies necessary to manage a pandemic.  
The call bell system is available in all areas and indicator panels in each area (link 1.2.8) During the tour of the facility, residents were observed to have easy access to the call bells.

Satisfaction survey September 2013 identified that 97% were happy with the security.  
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

##### **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:**

The facility has ceiling heating throughout communal areas and corridors. Each bedroom has an individual heating panel. All communal rooms and bedrooms are well ventilated and light. Six residents interviewed stated the temperature of the facility is comfortable. There is plenty of natural light in resident’s rooms, along corridors and in communal areas.

##### **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 policy (251) states the organisations philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated'. There is a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. There are also monthly restraint meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.   
The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has three residents on the register with an enabler in the form of bedrails. The file reviewed of two residents identified as having an enabler in the form of a bedrails included a comprehensive enabler assessment that covered alternatives and least restrictive options.  
The service currently has one resident in the hospital assessed as using a restraint. A register for each restraint is completed that includes a three-monthly evaluation.   
The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.1: Restraint approval and processes **(**HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

**Attainment and Risk:** FA

**Evidence:**

Only staff that have completed a restraint competency assessment are permitted to apply restraints. All staff restraint competency assessments have been completed.  
There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisational level and at a service level. Interview with the restraint coordinator and review of her signed job description identifies her understanding of the role

##### **Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)**

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint 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 2.2.2: Assessment **(**HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau.   
Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety.   
On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. The restraint file were reviewed. The file included a completed assessment that considered those listed in 2.2.2.1 (a) - (h).

##### **Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)**

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails, lap belts, and fall out chairs).   
The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plans identifies the specific interventions or strategies to try (as appropriate) before implementing restraint.   
Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed monthly during the facility restraint meetings and also as part of the three-monthly restraint reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions are initiated.   
The restraint coordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.  
The resident file refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed of the resident with restraint identified observations and monitoring as per their monitoring schedules. Restraint use is reviewed through the three monthly assessment evaluation, monthly restraint meetings and six-monthly multi-disciplinary meetings and includes family/whanau input.   
A restraint register is in place providing an auditable record of restraint use. This has been completed for the one resident requiring restraint

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint 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 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for the resident on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of the file of the resident using a bedrail identified that the evaluations are up-to-date and have reviewed (but not limited to); whether the desired outcome was achieved, whether the restraint was the least restrictive option and the impact of the use of restraint. Restraint is evaluated on a formal basis monthly at the facility restraint meeting and six monthly by the regional restraint team. Evaluation timeframes are predetermined by risk levels.

##### **Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)**

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:  
(a) Future options to avoid the use of restraint;  
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;  
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);  
(d) Whether the desired outcome was achieved;  
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;  
(f) The duration of the restraint episode and whether this was for the least amount of time required;  
(g) The impact the restraint had on the consumer;  
(h) Whether appropriate advocacy/support was provided or facilitated;  
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;  
(j) Whether the service's policies and procedures were followed;  
(k) Any suggested changes or additions required to the restraint education 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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

**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 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings.   
The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. The service has worked hard at minimising restraint (link 1.2.3.7).

##### **Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:  
(a) The extent of restraint use and any trends;  
(b) The organisation's progress in reducing restraint;  
(c) Adverse outcomes;  
(d) Service provider compliance with policies and procedures;  
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  
(g) Whether changes to policy, procedures, or guidelines are required; and  
(h) Whether there are additional education or training needs or changes required to existing education.

**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 are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system.  
The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, Community Lab, the infection control and public health departments at the local DHB.   
There is a monthly IC meeting and the staff and quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Minutes are available for staff.   
Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices. There is a staff health policy.

##### **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 (IC) committee is made up of a cross section of staff. The IC coordinator is new to the role. The facility also has access to an infection control nurse, public health, medlab, G.P's and expertise within the organisation.

##### **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:**

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.   
There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.  
Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.   
External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator, the infection control committee and expertise from the governing body

##### **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 infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator (registered nurse) has completed training with Bug control. The orientation package for staff includes specific training around hand washing and standard precautions. Toolbox training has been provided to staff around (but not limited to); UTIs, PPE, coughing & sneezing, Influ vaccine. IC training was last completed August 2013 (27 attended). Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.

##### **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 uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.  
Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager’s report on quality indicators.  
Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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