# Bupa Care Services NZ Limited - Windsor Park Specialist Senior Care Centre

## Current Status: 10 September 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

Windsor Park Care Home is part of the Bupa group. The service is certified to provide hospital, rest home and dementia level care. The service has a capacity of 80 residents. During the audit there were 24 rest home residents, 30 hospital residents and 17 residents in the dementia unit. Windsor Park is managed by an experienced registered nurse who is supported by a clinical manager and a Bupa operations manager.

There are improvements required around complaints management, embedding the quality and risk management system, analysing and evaluating outcomes data, corrective action plans, the health and safety programme, staff training on dementia, care plans, chemical safety and the definition of enablers.

## Audit Summary as at 10 September 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 10 September 2014

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

### Organisational Management as at 10 September 2014

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

### Continuum of Service Delivery as at 10 September 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 10 September 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 10 September 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

### Infection Prevention and Control as at 10 September 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 10 September 2014

### Consumer Rights

Windsor Park Care Home endeavours to provide care in a way that focuses on the individual residents' quality of life. Residents and relatives spoke positively about care provided at Windsor Park. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. There is a Maori health plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. The service functions in a way that complies with the Code of Health and Disability Services Consumers' Rights (Code of Rights). Information about the Code of Rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. A complaints process is in place. Residents and family are informed of the complaints process during their admission to the facility. There are required improvements around the complaints process. A complaints investigation was missing for one complaint lodged and the dates that actions are taken are not consistently being documented in the complaints register.

### Organisational Management

Windsor Park was purchased by Bupa in September 2013. The Bupa quality and risk management system has not been fully embedded and is a required improvement. Implementation has been hampered by two infectious outbreaks resulting in facility lockdowns in June and August 2014. 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. Key components of the quality management system link to the monthly quality meetings. Missing is evidence of quality indicator data being trended, and analysed for service improvements. This is a required improvement. Audit results are discussed in quality meetings. Corrective actions are discussed via staff meetings and in the form of corrective action memos. There is a required improvement around completing corrective actions in a timely manner.

A comprehensive Bupa health and safety and risk management programme is in the process of being implemented. Hazard identification, assessment and management policy guides practice. There are required improvements around health and safety relating to training the health and safety representatives, investigating all completed hazard identification forms and managing identified hazards in a prompt and effective manner. The service documents incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. There is evidence of assessment and first aid provided, registered nurse follow-up including clinical observations, review by GP and referral as appropriate.

There are comprehensive human resources policies in place. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an annual education schedule for all staff that is being implemented. A required improvement is around ensuring all caregivers have recognised dementia training within one year of working in the dementia unit.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are adequate to meet the needs of the residents.

### Continuum of Service Delivery

There is a comprehensive admission package available prior to or on entry to the service. The sample of residents’ records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There is an improvement required around the documentation of interventions to reflect the resident’s current needs. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed three monthly by the general practitioner.

An activities programme is implemented separately for the rest home/hospital area and for the dementia care unit. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the consumers groups.

All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans. Nutritious snacks are available 24/7.

### Safe and Appropriate Environment

Chemicals are stored securely throughout the facility. There is an improvement required around chemical safety. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well-maintained. There is a safe external walking path and gardens for the dementia care residents that are freely accessible.

There are adequate communal toilets and showers for the client group that are closely located near resident rooms without ensuite. 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 under floor heating and ceiling panels and the temperature is comfortable and constant. Electrical equipment is checked annually. All medical equipment and all hoists are scheduled for annual service. Hot water temperatures are monitored at least fortnightly. New hot water cylinders are currently being installed to improve the hot water temperatures in one of the rest home wings.

### Restraint Minimisation and Safe Practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation.

The service has six residents documented as using restraint in the form of bed rails and/or lap belts. Eight residents are documented as using an enabler. Residents who are using an enabler or a restraint undergo a full assessment prior to the enabler or restraint being put into place. This includes investigating alternative strategies. Family are consulted prior to restraint use.

There is one improvement required around ensuring the use of enablers is voluntarily requested by the resident.

### Infection Prevention and Control

The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme for Windsor Park is not yet due for review. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator is supported by the Bupa quality and risk team. Infection control training is provided at least twice each year 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.

# 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 - Windsor Park Care Centre |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Windsor Park Care Centre |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | **Start date:** | 10 September 2014 | **End date:** | 11 September 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:** | 71 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** |  XXXXX | **Total hours on site** | 12 | **Total hours off site** | 7 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 17 | Total audit hours | 41 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 12 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 79 | Number of relatives interviewed | 7 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | 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 Friday, 26 September 2014

## Executive Summary of Audit

**General Overview**

Windsor Park Care Home is part of the Bupa group. The service is certified to provide hospital, rest home and dementia level care. The service has a capacity of 80 residents. During the audit there were 24 rest home residents, 30 hospital residents and 17 residents in the dementia unit. Windsor Park is managed by an experienced registered nurse who is supported by a clinical manager and a Bupa operations manager.

There are improvements required around complaints management, embedding the quality and risk management system, analysing and evaluating outcomes data, corrective action plans, the health and safety programme, staff training on dementia, care plans, chemical safety and the definition of enablers.

**Outcome 1.1: Consumer Rights**

Windsor Park Care Home endeavours to provide care in a way that focuses on the individual residents' quality of life. Residents and relatives spoke positively about care provided at Windsor Park. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. There is a Maori health plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. The service functions in a way that complies with the Code of Health and Disability Services Consumers' Rights (Code of Rights). Information about the Code of Rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Staff training supports staffs’ understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. A complaints process is in place. Residents and family are informed of the complaints process during their admission to the facility. There are required improvements around the complaints process. A complaints investigation was missing for one complaint lodged and the dates that actions are taken are not consistently being documented in the complaints register.

**Outcome 1.2: Organisational Management**

Windsor Park was purchased by Bupa in September 2013. The Bupa quality and risk management system has not been fully embedded and is a required improvement. Implementation has been hampered by two infectious outbreaks resulting in facility lockdowns in June and August 2014. 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. Key components of the quality management system link to the monthly quality meetings. Missing is evidence of quality indicator data being trended, and analysed for service improvements. This is a required improvement. Audit results are discussed in quality meetings. Corrective actions are discussed via staff meetings and in the form of corrective action memos. There is a required improvement around completing corrective actions in a timely manner.

A comprehensive Bupa health and safety and risk management programme is in the process of being implemented. Hazard identification, assessment and management policy guides practice. There are required improvements around health and safety relating to training the health and safety representatives, investigating all completed hazard identification forms and managing identified hazards in a prompt and effective manner. The service documents incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. There is evidence of assessment and first aid provided, registered nurse follow-up including clinical observations, review by GP and referral as appropriate.

There are comprehensive human resources policies in place. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an annual education schedule for all staff that is being implemented. A required improvement is around ensuring all caregivers have recognised dementia training within one year of working in the dementia unit.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are adequate to meet the needs of the residents.

**Outcome 1.3: Continuum of Service Delivery**

There is a comprehensive admission package available prior to or on entry to the service. The sample of residents’ records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There is an improvement required around the documentation of interventions to reflect the resident’s current needs. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed three monthly by the general practitioner.
An activities programme is implemented separately for the rest home/hospital area and for the dementia care unit. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the consumers groups.
All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans. Nutritious snacks are available 24/7.

**Outcome 1.4: Safe and Appropriate Environment**

Chemicals are stored securely throughout the facility. There is an improvement required around chemical safety. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well-maintained. There is a safe external walking path and gardens for the dementia care residents that is freely accessible.

There are adequate communal toilets and showers for the client group that are closely located near resident rooms without ensuites. 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 under floor heating and ceiling panels and the temperature is comfortable and constant. Electrical equipment is checked annually. All medical equipment and all hoists are scheduled for annual service. Hot water temperatures are monitored at least fortnightly. New hot water cylinders are currently being installed to improve the hot water temperatures in one of the rest home wings.

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

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation.

The service has six residents documented as using restraint in the form of bed rails and/or lap belts. Eight residents are documented as using an enabler. Residents who are using an enabler or a restraint undergo a full assessment prior to the enabler or restraint being put into place. This includes investigating alternative strategies. Family are consulted prior to restraint use.

There is one improvement required around ensuring the use of enablers is voluntarily requested by the resident.

**Outcome 3: Infection Prevention and Control**

The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme for Windsor Park is not yet due for review. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator is supported by the Bupa quality and risk team. Infection control training is provided at least twice each year 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.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 44 | 0 | 6 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 9 | 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 1.1.13: Complaints Management  | The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Two complaints lodged in March 2014 were signed off as completed on 28 August 2014. The complaints register did not include any other dates to reflect that the complaint was managed in a timely manner. The care home manager reports that actions were taken earlier but dates had not been recorded. One complaint lodged on 3 June was acknowledged on 4 June with no evidence of further investigation or family contact.  | Ensure the complaints register includes all dates and actions taken. Ensure each complaint lodged is investigated.  | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.1 | The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | The Bupa quality and risk management system is understood by the care home manager and the clinical manager but has not been fully implemented. | Ensure the quality and risk management programme is fully implemented. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Key components of the quality management system link to the monthly quality meetings. The agenda includes reviewing the facility’s goals, internal audits, complaints and quality indicators. There are monthly accident/incident reports that break down the data collected across the facility and include staff incidents/accidents. Missing is evidence of data that is collected being trended, and analysed for service improvements. This is a required improvement. | Ensure that quality improvement data that is collected is analysed and evaluated, with evidence of systems improvements. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | There are corrective actions still pending from June 2014 that require attention. This is a required improvement. | Ensure corrective action plans are addressed in a timely manner.  | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Low | The health and safety committee has recently been established with health and safety representatives selected. The representatives have not undergone health and safety training yet. A hazard reporting process is in place. Nineteen hazard forms have been completed. Three identified hazards that were minimised were not added to the hazard register, four hazard identification forms were not investigated, one hazard that has been associated with residents’ falls and near misses has not been minimised or isolated to an appropriate level. The issue of chemical safety and storage on the cleaner’s trolley was identified with a timeframe to purchase lidded/locked cleaners trolleys. There is no evidence to support the identified hazard has been minimised (link to finding 1.4.1.1). A Bupa representative completed an internal health and safety audit in May 2014. Corrective actions have been identified but not all corrective actions have been addressed (link to finding 1.2.3.8). Staff and resident health and safety incidents are forwarded to the Bupa health and safety coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings.  | Ensure health and safety representatives received education and training on their role. Ensure all hazard identification forms are investigated. Ensure all identified hazards that cannot be eliminated are added to the hazard register. Ensure identified hazards are effectively dealt with in a timely manner.  | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management  | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Two caregiver staff who have been employed for longer than one year and work in the dementia unit have not completed their Careerforce dementia unit standard. This is a required improvement. | Ensure that all staff who work in the dementia unit are enrolled within six months of employment and complete the dementia standard papers within one year of employment. | 180 |
| 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 | (1) One hospital resident with XXXX (March 2014) is not linked to the long term care. (2) There is no link to the care plan of frequent faller status/corrective action for one hospital resident and one dementia care resident, (3) Medical and allied health interventions for resident conditions have not been linked to the resident care plan for a) rest home resident being actively treated for depression, b) resident discharged from hospital with XXXXX, c) dietary requirement for high potassium foods (as per dietitian recommendations) is not included in the dietary requirements on file and on kitchen copy (corrected on day of audit).  | Ensure care plans reflect the resident’s current needs and interventions are identified and documented.  | 60 |
| HDS(C)S.2008 | Standard 1.4.1: Management Of Waste And Hazardous Substances  | Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The open cleaner’s trolley with chemical bottles was observed to be left unattended several times throughout the audit. The issue of chemical safety and storage on the cleaners trolley was identified in May 2014 quality meeting minutes with a timeframe to October to purchase lidded/locked cleaners trolleys. There is no evidence to support the identified hazard has been minimised (link to finding 1.2.3.9). There are five chemical bottles in the cleaners without manufacturer labels. | Ensure the use of chemicals comply with legislative requirements.  | 90 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised.  | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | Two residents who were documented on the register as using an enabler were unable to voluntarily request the enabler, and therefore do not meet the criteria under Bupa’s definition of an enabler. | Ensure enablers are used only by residents who are able to voluntarily request the enabler. | 90 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Bupa policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The service provides families and residents with information on entry to the service and this information contains details relating to the Code. Employees receive training about consumers’ rights at orientation and through their on-going in-service training.

Residents are made aware of their rights through reading material offered on admission and discussions with them at intervals during their admission e.g. right to complain / right to support and the independent advocacy services available. Staff last underwent education and training on the Code of Rights on 14 March 2014.

Interviews with three of three caregiving staff, one enrolled nurse and three of three registered nursing staff (two registered nurses and one clinical manager) reflect their understanding of the key principles of the Code. Seven of seven residents (three rest home level and four hospital level) confirm that staff respect their privacy, and obtain daily consent and choice.

##### 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:**

A welcome information folder includes information about the Code, the complaints process and advocacy services through the Health and Disability Commission (HDC). There are opportunities to discuss this information prior to entry and/or at admission with the resident, family and as appropriate their legal representative. On-going opportunities occur via regular contact with the residents and families and via three-monthly residents’ meetings. Advocacy pamphlets and posters on the Code are clearly displayed at the facility.

Seven of seven residents (four hospital level and three rest home level) and seven of seven relatives (one with family in the dementia unit, four with family in the hospital and two with family in the rest home) confirm that information has been provided around the Code. The care home manager has an open door policy for concerns or complaints. Both residents and family report that they are comfortable discussing any concerns with the care home manager, and / or clinical manager.

##### 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:**

D14.4 There are clear instructions provided to residents in their admission pack regarding responsibilities of personal belongings. The Bupa document (‘Valuables Information for Residents’) is signed by the resident /relative/enduring power of attorney (EPOA).

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. Residents’ preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices. This includes voluntary participation in daily activities.

During the tour of the facility respect for privacy and personal space was demonstrated. Caregivers can explain ways resident privacy is maintained. Interviews with all seven residents (four hospital level and three rest home level) confirm that their privacy is upheld.

Interviews with three of three caregivers confirm that they provide the residents with choices during their daily cares. Interviews with all seven residents (four hospital level and three rest home level) and seven families confirm staff provide a respectful service and are approachable and friendly.

There is an abuse and neglect policy that is implemented. Staff are required to complete education on abuse and neglect. The most recent training on abuse and neglect took place on 10 March and 14 March 2014. There have been no reported instances of abuse and/or neglect. All seven residents and seven family members interviewed report that they are satisfied with the care that is being provided.

D4.1a Nine residents’ files reviewed identified that cultural and /or spiritual values and individual preferences are identified on admission with family involvement. Interviews with seven of seven residents (four hospital level and three rest home level) confirm that their values and beliefs are taken into account.

##### 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 The Māori health plan includes a description of how the facility will achieve the requirements set out in the ARC contract A3.1 (a) to (e). There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. These policies are cross referenced to the Bupa - Tikanga recommended best practice guidelines.

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with a local Maori advocacy service that provides support and advocacy for Maori. Cultural needs are assessed and identified in the residents’ care plans. There are currently no residents in the facility that identify as Maori.

D20.1i Annual cultural staff training is in place. It last took place on 25 June 2014 and was provided by a representative from the local Maori advocacy agency. The Maori health plan identifies the importance of whānau. Interviews with three of three caregivers confirm their understanding about the importance of family involvement. Discussions with seven of seven families confirm that they are regularly involved.

##### 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:**

Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Six-monthly multi-disciplinary team meetings assess if any changes are required in delivery of service and care plans. Family are invited to attend. Interviews with seven of seven family members (one with family in the dementia unit, four with family in the hospital and two with family in the rest home) confirm they are involved in the care planning and review processes.

D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. There is multi-cultural staff available and interviews with all seven residents confirmed that their individual values and beliefs were considered and discussed. Three of three caregiver staff were able to give specific examples of ways that they strive to meet the individual needs of the residents.

##### 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:**

A code of conduct is included in the employee pack with a signed copy held in each staff file (sighted in nine of nine staff files reviewed). Job descriptions include the responsibilities of the position. There are policies to guide practice including; discrimination, coercion, harassment and financial exploitation; code of conduct and a gifts policy. Interviews with three of three registered nurses (two staff nurses and one clinical manager), one enrolled nurse and three of three caregiving staff confirm their understanding of professional boundaries.

D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with all three caregiver staff confirm that they build a supportive relationship with each resident. This was also verified during interviews with all seven residents.

##### 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:**

The Bupa organisation has robust quality and risk management systems. These systems are in the process of being implemented at Windsor Park with evidence of staff engagement (link to findings in 1.2.3).

Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Across Bupa, benchmarking groups are established for the different levels of care including hospital, rest home and dementia level care. A quality improvement programme is implemented that includes performance monitoring.

ARC A2.2 Services are provided at Windsor Park Care Home that adhere to the health and disability services standards. The quality improvement programme includes performance monitoring.

A Bupa policy and procedure review committee meets monthly to discuss the policies identified for the upcoming 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 policies and procedures are sufficiently 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. The clinical manager and one registered nurse at Windsor Park are currently enrolled in the leadership and management skill development course.

Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This initiative is in the process being rolled out at Windsor Park.

Education is supported for all staff. Caregivers are required to complete approved foundations level two as part of their orientation. A nurse educator at Windsor Park is allocated eight hours per week to facilitate staff education. The service has introduced leadership development for qualified staff, attendance at external education, Bupa qualified nurses’ education day and regular education sessions at monthly meetings.

There are implemented competencies for caregivers, enrolled nurses and registered nurses. The standardised annual education programme, core competency assessments and orientation programmes have been implemented. Competencies completed include (but are not limited to); a) moving and handling, b) wound management, c) subcutaneous fluids, d) assessment tools and e) medications (insulin administration, controlled drug administration, syringe driver). RNs have access to external training.

Discussions with all seven residents and seven relatives were positive about the care the residents are receiving.

A2.2 Services are provided at a rest home, hospital and dementia level of care that adheres to the health and disability services standards. .

##### 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:**

A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if there is an incident/accident, a care or medical issue or a complaint arises. Contact with family/next of kin is recorded on the family contact sheet, on the incident/accident form and in the residents’ progress notes. Three-monthly residents’ meetings are held (meeting minutes sighted).

Staff underwent training on communication on 14 March 2014.

D16.4b Seven of seven families interviewed report that they are kept informed when their family members health status changes. Access to interpreter services is identified through the Southern District Health Board.

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

D11.3 The information pack is available in large print. It is read to those residents who require assistance.

D16.1bii; The information pack and admission agreement includes payment for items not included.

##### 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 a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code. There are signed general consents including outings on nine of nine resident files sampled (three rest home, four hospital, one dementia care and one respite dementia care). Resuscitation treatment plans and advance directives are appropriately signed in the nine of nine files reviewed.

Discussions with three caregivers (one rest home, one hospital and one dementia care) confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussions with two registered nurses identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

There is an advance directive policy. 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 will be completed as soon as possible after admission. There is evidence of family/EPOA discussion with the GP for a medically indicated not for resuscitation status.

D13.1: There were eight admission agreements and one short stay admission agreements sighted and all had been signed.

D3.1.d Discussion with seven families (one dementia, four hospital and two rest home) identified that the service actively involves them in decisions that affect their relative’s lives.

##### 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:**

An advocacy policy is in place. Residents are provided with a copy of the Code and HDC advocacy pamphlets on entry. Residents and family are informed about advocacy and support. Staff receive regular education and training on the role of advocacy services. The most recent in-service took place on the 10th and 14th March 2014.

Interviews with all seven residents confirmed that they are aware of their right to access support / advocacy. Residents and families are provided in writing the Health and Disability Commissioners (HDC) Advocacy contact details in the event that they have lodged a complaint and they do not feel that the complaint has been resolved.

D4.1d; Discussions with all seven relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.

ARC D4.1e All nine resident files reviewed includes information on residents, family/whanau and chosen social networks.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

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

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

**Attainment and Risk:** FA

**Evidence:**

The activities policy encourages links with the community. Families and friends are able to visit at times that meet their needs. Residents are supported by the activities staff to access the community as required and the service maintains key links with other community organisations.

Community services include pharmacy services for the supply of pharmaceuticals, a general practitioner who visits each resident three-monthly and as required, a physiotherapist 1.5 hours a week and a physiotherapy assistant who carries out the physiotherapy programmes designed by the physiotherapist 32.5 hours per week, a dietitian who is available on request, palliative care practitioners who are available upon referral, a podiatrist who visits the residents six-weekly and reviews all diabetics or as stipulated by the GP, and a hairdresser. Also available on request are the services of social work, speech-language pathology, psychiatry, and a geriatrician and nurse practitioner from community mental health.

A van is available for weekly group outings that include a hoist to accommodate wheelchairs. Residents are involved in community groups (e.g., Probis, Retired Services Association (RSA),

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The Bupa Complaints Management Policy and Procedure aligns with Code 10 of the Code and includes a complaints flow chart. Timeframes documented in policy for responding to a complaint meet HDC requirements. The care home manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. The complaints process is overseen by the South Island operations manager. A complaint management record is completed for each complaint lodged. A record of all complaints per month is maintained by the facility. Nineteen complaints have been lodged year-to-date in 2014. No complaints have been lodged against the facility with the Health and Disability Commissioner’s Office.

The complaints procedure is provided to resident/relatives at entry. Discussions with seven of seven residents (four hospital level and three rest home level) and seven relatives confirm they were provided with information on complaints and complaints forms. Complaints forms are also available at the front reception area

Nineteen complaints were reviewed. There was a lack of consistent evidence to reflect that all complaints had been dealt with in a timely and comprehensive manner. These are required improvements.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A complaint management record is completed for each complaint lodged. A record of all complaints per month is maintained by the facility. Nineteen complaints have been lodged year-to-date in 2014. No complaints have been lodged against the facility with the Health and Disability Commissioner’s Office.

Nineteen complaints were reviewed. There are required improvements around the complaints process. There was a lack of evidence to reflect that all complaints had been dealt with in a timely and comprehensive manner. There was also lack of evidence of trending and analysing the 19 complaints received in 2014 (link to finding 1.2.3.6). There was evidence in the quality and staff meeting minutes of complaints received being discussed with staff.

**Finding:**

Two complaints lodged in March 2014 were signed off as completed on 28 August 2014. The complaints register did not include any other dates to reflect that the complaint was managed in a timely manner. The care home manager reports that actions were taken earlier but dates had not been recorded. One complaint lodged on 3 June was acknowledged on 4 June with no evidence of further investigation or family contact.

**Corrective Action:**

Ensure the complaints register includes all dates and actions taken. Ensure each complaint lodged is investigated.

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Windsor Park was purchased by Bupa in September 2013. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Windsor Park Care Centre has specific quality goals for 2014 that are around team building, tool box talk champions, implementing the Bupa personal best programme, enhancing the physical environment, cultural safety and pastoral care, restructuring staff rosters, reducing resident falls, enhancing the activities programme, and providing attractive and nutritious meals.

The facility provides rest home level, hospital level and dementia-specific care for up to 80 residents. There were 71 residents living at the facility during the audit. This included 24 of 25 available rest home level beds, 30 of 35 available hospital level beds and 17 of 20 available secure dementia level beds.

Bupa strives to implement robust quality and risk management systems implemented across its facilities.

The care home manager has been in her role since December 2013. She is a registered nurse with previous experience psychiatric nursing, and various nursing management roles. She is supported by the operations manager for the lower South Island.

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.

D17.3di The care home manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

During the absence of the care home manager, responsibilities are delegated to the clinical manager and if needed, the Bupa operations manager for the lower South Island. Bupa has locum managerial staff available to cover managers during periods of extended leave.

##### 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:** PA Low

**Evidence:**

Windsor Park was purchased by Bupa in September 2013. The Bupa quality and risk management system has not been fully embedded and is a required improvement. Implementation has been hampered by two infectious outbreaks resulting in facility lockdowns in June and August 2014. Interviews with staff and review of meeting minutes and quality action forms demonstrate a culture that is moving towards quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, 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. The facility has 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 policies 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 Bupa organisational policy and procedure review committee is in place. This group meets monthly to discuss the policies identified for the scheduled 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 Bupa 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.

The fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all care home managers and clinical 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.

Key components of the quality management system link to the monthly quality meetings. The agenda includes reviewing the facility’s goals, internal audits, complaints, and quality indicators (e.g., infections, accidents and incidents, complaints). Monthly accident/incident reports break down the data collected across the facility. Data includes staff incidents/accidents. Missing is evidence of quality indicator data being trended, and analysed for service improvements. This is a required improvement.

The monitoring programme includes (but is not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, health and safety, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee.

Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Audit results are discussed in quality meetings. Corrective actions are discussed via staff meetings and in the form of corrective action memos. There are corrective actions still pending from June 2014 that require attention. This is a required improvement.

D19.3: A comprehensive Bupa health and safety and risk management programme is in the process of being implemented (link to finding 1.2.3.1). Hazard identification, assessment and management policy guides practice. On-going reviews of the health and safety objectives are evidenced in the quality meeting minutes. A health and safety notice board is in place. A health and safety committee was established at the last quality meeting (27 August 2014). There are required improvements around health and safety. Staff training on their role as health and safety representatives has not taken place and is a required improvement. Completed hazard identification forms are not consistently being investigated or added to the hazard register and is a required improvement. Lastly, one identified hazard that has been recalled by staff as being the cause of accidents and near misses has not been documented in the hazard register. Nor is this hazard being managed in a safe manner as residents continue to have near misses as reported by three of three caregivers. There is evidence of the review of the hazard register in July and August 2014.

D19.2g Falls prevention strategies are in place to monitor falls on a case by case basis to minimise future falls. A falls management group has recently been established. Falls prevention strategies include the completion of falls risks assessments, sensor mats, the availability of physiotherapy to assist in the selection of appropriate mobility equipment and closely monitoring those residents at risk of falling.

##### 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:** PA Low

**Evidence:**

Windsor Park was purchased by Bupa in September 2013. They are still in the process of implementing Bupa’s quality and risk management system. The Bupa quality and risk management system has not been fully embedded and is a required improvement. This includes trending an analysing data (link to finding 1.2.3.6), completing corrective actions in a timely manner (link to finding 1.2.3.8) and fully implementing the health and safety programme (link to finding 1.2.3.9).

Interviews with staff and review of meeting minutes and quality action forms demonstrate a culture that is moving towards quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team.

**Finding:**

The Bupa quality and risk management system is understood by the care home manager and the clinical manager but has not been fully implemented.

**Corrective Action:**

Ensure the quality and risk management programme is fully implemented.

**Timeframe (days):** 180 *(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:** PA Low

**Evidence:**

Key components of the quality management system link to the monthly quality meetings. The agenda includes reviewing the facility’s goals, internal audits, complaints and quality indicators. There are monthly accident/incident reports that break down the data collected across the facility and include staff incidents/accidents. Missing is evidence of data that is collected being trended, and analysed for service improvements. This is a required improvement.

**Finding:**

Key components of the quality management system link to the monthly quality meetings. The agenda includes reviewing the facility’s goals, internal audits, complaints and quality indicators. There are monthly accident/incident reports that break down the data collected across the facility and include staff incidents/accidents. Missing is evidence of data that is collected being trended, and analysed for service improvements. This is a required improvement.

**Corrective Action:**

Ensure that quality improvement data that is collected is analysed and evaluated, with evidence of systems improvements.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Corrective actions are discussed via staff meetings and in the form of corrective action plans. Each corrective action is signed off by the manager when completed. A folder containing a significant number of pending corrective actions that date to June 2014 were available for sighting.

**Finding:**

There are corrective actions still pending from June 2014 that require attention. This is a required improvement.

**Corrective Action:**

Ensure corrective action plans are addressed in a timely manner.

**Timeframe (days):** 180 *(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:** PA Low

**Evidence:**

A comprehensive Bupa health and safety and risk management programme is in place and is in the process of being implemented at Windsor Park (link to finding 1.2.3.1). Hazard identification, assessment and management policy guides practice. On-going reviews of the health and safety objectives are evidenced in the quality meeting minutes. A health and safety notice board is in place. A health and safety committee was established at the last quality meeting (27 August 2014). Staff have not received education and training on their role as health and safety representatives. Completed hazard identification forms are not consistently being investigated or added to the hazard register where indicated. One identified hazard that has been recalled by staff as being the cause of accidents and near misses has not been documented in the hazard register. There is evidence of the review of the hazard register in July and August 2014.

**Finding:**

The health and safety committee has recently been established with health and safety representatives selected. The representatives have not undergone health and safety training yet. A hazard reporting process is in place. Nineteen hazard forms have been completed. Three identified hazards that were minimised were not added to the hazard register, four hazard identification forms were not investigated, one hazard that has been associated with residents’ falls and near misses has not been minimised or isolated to an appropriate level. The issue of chemical safety and storage on the cleaner’s trolley was identified with a timeframe to purchase lidded/locked cleaners trolleys. There is no evidence to support the identified hazard has been minimised (link to finding 1.4.1.1).

A Bupa representative completed an internal health and safety audit in May 2014. Corrective actions have been identified but not all corrective actions have been addressed (link to finding 1.2.3.8). Staff and resident health and safety incidents are forwarded to the Bupa health and safety coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings.

**Corrective Action:**

Ensure health and safety representatives received education and training on their role. Ensure all hazard identification forms are investigated. Ensure all identified hazards that cannot be eliminated are added to the hazard register. Ensure identified hazards are effectively dealt with in a timely manner.

**Timeframe (days):** 90 *(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 includes responsibilities for reporting category 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). Bupa have introduced a dedicated email address for informing the operations team of any category ones. A monthly category one summary is sent out to care homes for learning.

D19.3b; The service documents 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. A sample of 20 incident/accident forms were reviewed for 2014. There is evidence of assessment and first aid provided, registered nurse follow-up including clinical observations, review by GP and referral as appropriate. The development of short term care plans as a result of an accident/incident was evident although missing is updated information when a resident is at increased risk of falling (link to finding 1.3.6.1). Also missing is evidence of the analysis of accident and incident data (link to finding 1.2.3.6). The registered nurse reports that a falls management group has recently been established to assist in the analysis of falls data.

Discussions with the care home manager and operations manager confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications. The facility has had two coroner’s investigations since Bupa purchased this facility in 2013. One investigation has been closed and the second investigation is still underway. The Ministry of Health is aware of both investigations.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A register of RN practising certificates is maintained, both at the 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. Current practicing certificates were sighted for the enrolled nursing staff, general practitioners, physiotherapist, podiatrist, and pharmacy.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were randomly selected for review (five caregiver staff, two registered nursing staff, and two activities staff). All nine files contain signed employment agreements and job descriptions. Annual performance appraisals are due this month.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse (RN), caregiver staff) and includes completed competencies. New staff are buddied with experienced staff until competency is established. During this period they do not work independently with residents. The caregiver orientation booklet is aligned with the New Zealand Qualification Authority (NZQA) Foundation Skills Unit Standards. On completion of orientation they have effectively attained their first (level two) national certificate. They are then able to continue with NZQA Core Competencies Level 3 Unit Standards. (These align with Bupa policy and procedures). Eighteen of twenty-eight permanent and casual caregivers hold a qualification such as a relevant ACE or National Certificate. Completed orientation booklets are held either in staff files or with the nurse educator. Staff interviewed (three caregivers, one clinical manager and two registered nursing staff) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

There is an annual education schedule for all staff that is being implemented. One RN is the designated educator and is allocated eight hours per week to assist with education activities. She is a Careerforce assessor and also assesses staff competencies. Staff education summary sheets are in place to monitor attendance. There is an RN training day provided through Bupa that covers clinical aspects of care.

Discussions with staff and management confirm that a comprehensive education and training programme in relevant aspects of care and support is in place. The RNs have attended relevant Bupa training days. RNs have completed a range of education including (but not limited to) infection control, outbreak management, dementia and wound management.

Two caregiver staff who have been employed for longer than one year and work in the dementia unit have not completed their Careerforce dementia unit standard. This is a required improvement.

##### 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:** PA Low

**Evidence:**

There is an annual education schedule for all staff that is being implemented. One RN is the designated educator and is allocated eight hours per week to assist with education activities. She is a Careerforce assessor and also assesses staff competencies. Staff education summary sheets are in place to monitor attendance. There is an RN training day provided through Bupa that covers clinical aspects of care.

Discussions with staff and management confirm that a comprehensive education and training programme in relevant aspects of care and support is in place. The RNs have attended relevant Bupa training days. RNs have completed a range of education including (but not limited to) infection control, outbreak management, dementia and wound management.

Two caregiver staff who have been employed for longer than one year and work in the dementia unit have not completed their Careerforce dementia unit standard. This is a required improvement.

**Finding:**

Two caregiver staff who have been employed for longer than one year and work in the dementia unit have not completed their Careerforce dementia unit standard. This is a required improvement.

**Corrective Action:**

Ensure that all staff who work in the dementia unit are enrolled within six months of employment and complete the dementia standard papers within one year of employment.

**Timeframe (days):** 180 *(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 that aligns with contractual requirements and includes skill mixes. The facility has a full time care home manager who is also a registered nurse. A full time clinical manager is onsite Monday – Friday.

The care home manager (RN) and clinical manager (RN) work full-time, Monday – Friday. A minimum of one registered nurse is onsite seven days a week, 24 hours a day. An enrolled nurse is rostered on the day shift for the rest home three days a week. A senior caregiver covers the rest home in her absence. The dementia unit is staffed with two caregivers on the AM shift, two caregivers on the PM shift and one caregiver on the night shift. An activities coordinator is scheduled in the dementia unit from 10am – 1830 seven days a week.

The hospital is staffed with five caregivers on the AM shift, four caregivers on the PM shift and one caregiver on the night shift. All seven residents and seven families interviewed state that there is sufficient staff on duty.

##### 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. Residents’ files are protected from unauthorised access by being held in secure areas. Archived records are secure in a separate locked room at the facility.

Care plans and notes are legible and where necessary signed and dated by the RN. All resident records contain the name of resident and the person completing an entry.

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 nurse including designation.

##### 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. Seven residents (three rest home, four hospital) and seven relatives (two rest home, four hospital and one dementia) interviewed stated they were well informed upon admission. The service has a well-developed enquiry information pack available for potential residents and an admission pack for /families/whānau at entry. The information pack includes all relevant aspects of the 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.
The care home manager (registered nurse) and clinical manager (registered nurse) screens all admissions to ensure a needs assessment has been completed and the service can provide the level of care and a bed is available. A request is made for the most recent needs assessment. There is good liaison and communication with the needs assessors and social worker. The service provides emergency respite services on referral.
There is an admission policy, a resident admission procedure and short stay admission agreement for respite/short stay resident admissions.

E4.1.b There is written information on the service philosophy and practices particular to the unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:
1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.
D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.
D14.1: Exclusions from the service are included in the admission agreement.
D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
E3.1: Two files reviewed include a needs assessment as requiring specialist dementia cares/respite care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

There is an admission information policy. The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry to residents and communicates this to residents/family/whānau. Potential residents would be referred back to the referring agency if entry is 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:**

Bupa Windsor provides rest home, hospital and dementia level of care. There is a registered nurse (RN) based in the hospital who undertakes the initial nursing assessment and risk assessments on admission, with the initial support plan completed within 24-48 hours of admission. This is evident in eight of nine files sampled (three rest home, four hospital and two dementia care (includes one respite care). There is a short stay nursing assessment and support plan in place for the dementia care respite resident. Within three weeks, the long term care plan is developed in eight of nine permanent resident files sampled. One dementia care resident is in respite care.

In all eight permanent resident files sampled (three rest home, four hospital and one dementia care) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission within 48 hours by the resident’s general practitioner (GP) in the eight permanent files sampled. There is a GP current history and medication list in the dementia respite care residents file. It was noted in residents’ files reviewed that the GP has assessed the resident as stable and is to be seen three monthly or earlier if required. The GP (interviewed) provides shared medical services for the residents of Windsor Park. The GPs have a maximum of 25 residents each. They carry out the routine three-monthly visits and are available at other times as required. There is GP cover at the medical centre until 9pm and at the local hospital casualty unit after hours. The GP is involved in the three-monthly reviews and family discussions around options for care, resuscitation status and medical care. The families are invited to attend GP visits and reviews. The GP is positive about the communication and clinical assessments. Communication is predominantly by fax (sighted in resident files).

The service contracts a qualified physiotherapist and employs a physiotherapy assistant who works under the direct supervision of the physiotherapist. The physiotherapy assistant (interviewed) implements the physiotherapy programme as directed and is involved in the facility exercise programme twice a week. She assists with two person walks. She works predominantly within the hospital wing and referrals to assess residents in other areas come through the RN or GP to the physiotherapist. The team also assess equipment and provide training to staff on moving and handling (last attended April 2014 – 26 staff). A podiatrist visits regularly.

Staff could describe a verbal handover (observed in the hospital wing) at the end of each duty that maintains a continuity of service delivery. There is a written handover book that identifies any significant events that have occurred such as falls, infections and changes to health. Progress notes are written on each shift, dated, timed, and signed with designation. RN entries are also identified with a “RN” stamp. Nine files (three rest home, four hospital, one dementia care, one respite care) identified integration of allied health and a team approach. The RN community mental health nurse for the older person (interviewed) receives referrals from the GP. A medical investigation is initiated by the GP before referral to the service. The consultant psychiatrist liaises with community nursing to assess behavioural, depressive, psychosis, delirium and medication related disorders. The mental health team follow-up residents discharged from the hospital. The service may refer residents back to the service for up to six months without a GP referral. There are documented notes to evidence geriatrician, social worker and nursing specialist involvement in the integrated care of the residents as appropriate.

In the nine files sampled (including the dementia respite care) an activities coordinator in consultation with family/resident has completed initial activity assessment and the activities sections of the “My day, my way” care plans. Each resident has a “map of life” in their file completed in consultation with the resident/family as appropriate.

Tracer Methodology dementia care:

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

Tracer methodology rest home:

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

Tracer methodology hospital resident:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Windsor Park Care Home uses the Bupa assessment booklets and person centred templates for all residents. The assessment booklet provides in-depth assessment tools including; falls, Braden pressure area, skin, mini nutritional, continence, pain (verbalising and non-verbalising), dependency and activities. Nutritional requirements are completed on admission. Additional risk assessment tools include behaviour, cultural and wound assessments as applicable. The outcomes of risk assessments are reflected in the care plan.
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.
E4.2; One dementia resident file and one dementia respite care file reviewed included an individual assessment (specific dementia needs) that included identifying diversional, motivation and recreational requirements.
E4.2a: Challenging behaviour charts and a behaviour analysis tool are completed where required, as a result de-escalation strategies have been included in the long term care plan.

##### 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 are comprehensive and demonstrate service integration and input from allied health. Residents (three rest home and four hospital) and families (two rest home, four hospital and one dementia care) interviewed confirm care delivery and support by staff is consistent with their expectations. Residents and families interviewed stated that they and their family are involved in planning their care plan and at evaluation. There is documented evidence on the care plan and in the family contact form of family involvement in the care plan process.
The long-term care plan was completed within three weeks in six of nine residents files sampled. One resident is on respite care and one hospital and one rest home resident has not been at the service long enough for a six-monthly review.

There is a long term 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. Long term residents' care plans reviewed on the day of the audit (three rest home, four hospital, one dementia care and one dementia respite care) provide evidence of individualised support, however there is an improvement required around the documentations of interventions (link 1.3.6.1).
D16.3k: Short term care plans are in use for short term needs and changes in health status. Short term care plans sighted include; falls, fluid restriction, UTI, blood pressure monitoring, wounds, skin tears, chest infection, weight loss, and norovirus.
D16.3f: The nine 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:**

The registered nurses complete residents’ care plans. A care summary is readily available for caregivers. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all nine residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. There is documented evidence (family contact sheet and in progress notes) of family notification when a resident health status changes including infections, incidents/accidents, GP visits, medication changes, care plan reviews, challenging behaviours, appointments and transfers. Seven residents and seven relatives interviewed are complimentary of care received at the facility.

Dressing supplies are available and sighted in all treatment rooms. Dressing trolleys are well stocked. All staff report that there are always adequate continence supplies and dressing supplies. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Continence management in-services and wound management in-services (skin tears and pressure areas attended September 2014) have been provided. The clinical manager (interviewed) states the nursing specialists for wound and continence management are supportive and readily available for advice and education. There is evidence of wound nurse specialist involvement in chronic wounds/pressure areas. There are seven skin tears (one dementia care, four hospital and one rest home). There are two minor lesions in the rest home, three in the hospital and one in the dementia care wing. The RN on duty carries out assessment, evaluations and dressing changes. The enrolled nurse in the rest home completes dressing changes under the indirect supervision of the RN. All enrolled nurse assessments and evaluations are countersigned by the RN. There are photos for one rest home resident with long term chronic leg ulcers and specialist involvement. There are ten grade one pressure areas in the hospital wing (four buttock, three heels, one spine, one sacrum) and one grade one pressure area of foot (noted as deteriorating at last evaluation ). There is an improvement required around linking chronic wounds to the care plans.

There is a physiotherapist available by referral follows up residents post falls, equipment advice as required. There is an improvement required around documenting the falls status for frequent fallers in the care plan. The RN completes risk tool assessments on admission including continence, falls, transfer plans, pressure area risk, nutritional assessments, pain assessments, cultural assessment and dependency rating.
Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, Iowa pain monitoring tool and behaviour monitoring chart.

Discharge information, GP medical notes and allied health notes (dietitian, speech language, physiotherapy) are made available in the integrated file. There is an improvement required around the documentation of medical and allied health interventions in the care plan to reflect the resident’s current medical 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:**

There is evidence of wound nurse specialist involvement in chronic wounds/pressure areas. The RN on duty carries out assessment, evaluations and dressing changes. The enrolled nurse in the rest home completes dressing changes under the indirect supervision of the RN. All enrolled nurse assessments and evaluations are countersigned by the RN. There are photos for one rest home resident with long term chronic leg ulcers and specialist involvement. There are ten grade one pressure areas in the hospital wing (four buttock, three heels, one spine, one sacrum) and one grade one pressure area of foot (noted as deteriorating at last evaluation ). There is an improvement required around linking chronic wounds to the care plans. The registered nurses complete residents’ care plans. Pressure area resources are identified in care plans and include position changes, air alternating mattresses and pressure area cushions.

The RN completes risk tool assessments on admission including continence, falls, transfer plans, pressure area risk, nutritional assessments, pain assessments, cultural assessment and dependency rating. Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, Iowa pain monitoring tool and behaviour monitoring chart. There is a physiotherapist available by referral follows up residents post falls, equipment advice as required. There is evidence of RN assessment post falls and family contact. Discharge information, GP medical notes and allied health notes (dietitian, speech language, physiotherapy) are made available in the integrated file.

**Finding:**

(1) One hospital resident with XXXXXX (March 2014) is not linked to the long term care. (2) There is no link to the care plan of XXXXX status/corrective action for one hospital resident and one dementia care resident, (3) Medical and allied health interventions for resident conditions have not been linked to the resident care plan for a) rest home resident being actively treated for XXXXXX, b) resident discharged from hospital XXXXXX, c) dietary requirement for high potassium foods (as per dietitian recommendations) is not included in the dietary requirements on file and on kitchen copy (corrected on day of audit).

**Corrective Action:**

Ensure care plans reflect the resident’s current needs and interventions are identified and documented.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a team of four activities co-ordinators employed to implement the rest home/hospital activity programme and a separate activity programme in the dementia special care unit. Two activity co-ordinators are qualified diversional therapists and another has completed level three core competencies and the dementia course. There is a company occupational therapist that oversees the overall programme. The activity team attend the Bupa training days and all activity co-ordinators hold a current first aid certificate. There is a seven day programme in the dementia unit that involves the activity co-ordinator and caregivers on duty as observed on the day of audit. An activity co-ordinator is employed from 2-6pm daily to implement the afternoon programme across the services. The focus on the afternoons is to also spend one on one time with residents who are unable to participate or choose not to participate in the group activities. The programmes include activities that meet the needs and preferences of the consumer groups however many activities are integrated. Bupa has set activities on the programme that is delivered with the flexibility to add site specific activities, entertainers and outings. The residents in the dementia unit attend entertainment and activities in the rest home/hospital wings under supervision. Programmes are displayed. Variations to the programme are made known to the residents.

There is a fully integrated rest home/hospital activity programme which includes (but not limited to) newspaper reading, exercise programme, bowls, housie, target mat, small group activities, DVDs and ice-creams, men’s group and happy hours. Some activities occurring in the dementia special care unit include sensory actives such as baking, reminiscing, card making, short stories, nail and hand cares/massages, dance and music.

Community visitors to the facility include musical entertainers (county and western, piano, music club, pre-schoolers), probes choir, and RSA visits on Sundays. There is a church service held twice monthly. Festive occasions and birthdays are celebrated. There are four volunteers involved in assisting with the activity programme (housie, games) and church services. Two volunteers are accredited visitors from age concern who visit two residents on individual basis. Outings are scheduled weekly for the residents in each service. There are outings for scenic drives, country drives, picnics etc. The service has a wheel chair hoist van. Two staff accompany residents on outings. Residents are kept informed of upcoming events and they receive regular newsletters. A recent quality initiative is the development of a virtual shopping book with descriptions, costs and order forms. Residents place their orders as required for the fortnightly shop.

The family/resident completes a Bupa Map of Life on admission which includes previous hobbies, community links, family, and interests. The individual activity plan in all residents’ files sampled identifies activities and community links that reflect the resident’s normal patterns of life. The activity plan (incorporated into the Bupa My Day, My Way long term care plan is reviewed six-monthly, at the same time as the care plan six monthly multidisciplinary review. Individual activities participation registers are maintained. Activity notes are written into the integrated progress notes for any significant activity event/participation. Residents have the opportunity to provide feedback on the activity programme through resident meetings and resident satisfaction surveys.

##### 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:**

Care plans are reviewed and evaluated by the registered nurse at least six monthly in six of nine files sampled. One dementia care resident is respite care. One hospital and one rest home resident have not been at the service long enough for a six monthly care plan evaluation. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident. Family members are invited to attend the MDT review. The MDR checklist identifies the family member who has attended the MDR review.
There is at least a one- three monthly review by the medical practitioner.
There are short-term care plans available to focus on acute and short-term issues. These are evaluated at regular evaluations.
D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

Referrals to other health and disability services are evident in the sample group of residents’ files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents’ files. Examples of referrals sighted were to needs assessor, social worker, occupational therapist, physiotherapy, dietitian, mental health services, speech language therapist, and RN community mental health nurse, hospital specialists, renal unit and podiatry.

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 respite to rest home, hospital and dementia care level of care.

D 20.1 discussions with the clinical manager and two registered nurses identified that the service has access to GPs, ambulance/ emergency services, allied health, dietitians, physiotherapy, continence and wound specialists and social workers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident’s file. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification of appointments and transfers. Seven relatives confirmed on interviewed they are notified and kept informed of the resident’s condition. 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:** FA

**Evidence:**

Medications are managed appropriately in line with accepted guidelines. The locked medication room in the rest home wing holds the main supplies and controlled drug cabinet. The hospital wing has a locked cupboard within the nurse’s station for medications and a locked medication trolley in the nurse’s station. There is a locked medication room off the nurse’s station in the dementia wing. Registered nurses in the hospital, enrolled nurses in the rest home and senior caregivers in the dementia wing administer medications. All medication competent staff have completed annual medication competencies for oral administrations, controlled drugs, oxygen and nebuliser administration and insulin competencies. RNs complete additional competencies for peritoneal dialysis, subcutaneous fluids and syringe driver.

The service uses robotic roll system and PRN medications are being changed over from medication bottles to blister packs as the expiry dates fall due. All medications are checked on delivery against the medication chart and signed off on the pharmacy order sheet and on the medication pack (sighted). Discrepancies are fed back to the supplying pharmacy. Inventory and pharmacy stock are checked weekly. There is a supply of hospital stock held in the locked drug cabinet and safe in the rest home wing. The controlled drug prescription pad is held in a locked safe in the care home manager’s office. There is an antibiotic stock held for GP prescribing. All controlled drugs are checked weekly. The service does not have standing orders. Verbal orders are used if required and these are sighted in the resident’s files (two staff signatures and GP sign off within a timely manner. All eye drops (and creams) in the medication trolleys are dated on opening. There is a specimen and medication fridge in the rest home medication room. Medication fridge temperatures are checked at east weekly and temperatures are within acceptable ranges. Oxygen and suction is checked weekly (checklist sighted). Oxygen concentrators are available.

There are currently two rest home residents self-administering. Medications being self-administered are identified o the medication chart for each resident. Competency assessments, responsibility and consents have been completed and reviewed for the two residents by the clinical manager and GP. Medications are stored safely in the resident’s rooms. Eighteen resident medication signing sheets are sampled. Signing sheets correspond to instructions on the medication chart. PRN medications are signed, dated and timed. The medication folder contains information on crushable medications, diabetic management, GP specimen signatures and warfarin precautions. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies e) short course medications f) warfarin. Iowa and modified abbey pain assessments and blood sugar level recordings are kept with the resident medication chart.

Eighteen medication profiles sampled (four dementia care, eight hospital unit and six rest home) are legible (in GPs writing), up to date and reviewed at least three monthly by the G.P. There are photos (dated) and allergy status documented on all 18 medication charts sampled.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**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:**

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'. There is a monthly on-line forum for all Bupa facilities cooks. There are three kitchen staff on duty each day including a qualified cook (8am-4.30pm) and morning and afternoon kitchen hand.
The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site in the main kitchen. Meals are served from the Bain Marie in the kitchen to residents in the rest home dining room and transported in hot boxes to Bain marries to the hospital and dementia unit kitchenettes, and served by care staff.

Resident likes and dislikes are known and alternative choices offered. The residents have a nutritional profile developed on admission and the kitchen staff receive a copy which identifies the residents’ dietary requirements and likes and dislikes. Special diets include gluten free, no pork and moulied. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Staff are observed in the hospital wing assisting residents with their meals at the midday meal. End cooked food temperatures are monitored (records sighted). All foods are dated in the chiller, fridges and freezers within the kitchen. Meat is stored at the bottom of the chiller. All fridges and freezers are temperature monitored including the kitchenette fridges (recordings sighted). Chilled and frozen goods have temperatures checked and recorded on delivery. The service has a large workable kitchen that contains a walk-in pantry, freezer, fridges, chillers, combi-oven, Bain marries, microwave and commercial baking equipment. Equipment has been tested and tagged March 2014. The dishwasher is checked monthly by the chemical provider. All chemicals are stored safely .Safety data sheets are available. Daily cleaning schedules are maintained with high walls and ceilings schedule as part of the planned maintenance schedule for maintenance.
Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number of audits completed including; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit. The cook (interviewed) receives feedback on the food service and meals from the resident meeting minutes. Monthly kitchen meetings are held.
There is a kitchen manual that includes (but is not limited to hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety.
E3.3f; There is evidence of additional nutritious snacks available over 24 hours. There are daily deliveries daily to the dementia units of sandwiches, fruit platters, protein drinks, cakes, desserts, finger foods, yoghurts etc.
D19.2; Staff have been trained in safe food handling NZQA units 167 and 168 and chemical safety January 2014.

##### 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:** PA Low

**Evidence:**

There is a chemical/substance safety policy. There are policies on the following: waste disposal policies for 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. A procedure is in place for the disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff. Staff attended chemical safety education in January 2014. Chemicals are stored in a locked cupboard. Safety data sheets and product wall charts are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff are observed wearing appropriate personal protective clothing when carrying out their duties. There is an improvement required around chemical safety.

##### 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:** PA Low

**Evidence:**

Management of waste and hazardous substances is covered during orientation of new staff. Staff attended chemical safety education in January 2014. Chemicals are stored in a locked cupboard. There are safety data sheets and product wall charts available for staff. Staff attended chemical safety training in January 2014. Quality meeting minutes May 2014 identified the need to store chemicals safely on the cleaner’s trolley.
**Finding:**

The open cleaner’s trolley with chemical bottles was observed to be left unattended several times throughout the audit. The issue of chemical safety and storage on the cleaners trolley was identified in May 2014 quality meeting minutes with a timeframe to October to purchase lidded/locked cleaners trolleys. There is no evidence to support the identified hazard has been minimised (link to finding 1.2.3.9). There are five chemical bottles in the cleaners without manufacturer labels.

**Corrective Action:**

Ensure the use of chemicals comply with legislative requirements.

**Timeframe (days):** 90 *(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 building warrant of fitness which expires on 6 August 2015. Reactive and preventative maintenance occurs. There is a full-time maintenance person on staff. There is a 52 week planned maintenance programme in place. The checking of medical equipment including hoists was postponed due to an outbreak and checks have been re-scheduled. The hot water temperatures are monitored fortnightly on a room rotation basis. There are plumbers on-site installing two new hot water cylinders with more efficient gas burners to maintain hot water temperatures between 40-45 degrees as there have been problems with a low water temperature in one of the wings. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are wide are promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating with shade sails in place. There is wheelchair access to all areas. There is a designated resident smoking area for the rest home and hospital area.
ARC D15.3. The three caregivers interviewed (one hospital, one rest home and one dementia care) and two RNs (hospital) stated that they have all the equipment referred to in care plans and necessary to provide care, including tilting shower chairs, shower trolleys, commodes, slidy sheets, electric beds, ultra-low beds sling and standing hoists, wheel-on scales wheelchairs, sensor mats, landing mats, mobility aids, continence supplies, dressing and medical supplies.
Registered nurses stated that when something that is needed is not available, management provide this within a timely manner.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.
E3.3e; There are quiet, low stimulus areas that provide privacy when required.
E3.3e: E3.4.c; There is a safe and secure outside walking area and gardens area that is easy to access for dementia residents.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms have hand basins. The rest home wings (Waimea and Croydon) have bedrooms with ensuites. There are two hospital rooms with shared ensuite and two rooms with their own ensuites. There are adequate numbers of communal toilets and shower rooms located near the bedrooms without ensuite facilities. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Privacy curtains are in place. Slide signs indicate whether the communal toilet/showers are vacant or in use.
Seven residents interviewed (four hospital, three rest home) 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:**

All bedrooms are single. The hospital bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Three caregivers (one rest home, one hospital and one dementia care) and two RNs (interviewed) report that rooms have sufficient rooms to allow cares to take place. The bedrooms have wide doors for bed evacuation or 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 are spacious open plan lounges and dining rooms in the rest home, hospital and dementia wings. The service has a family room with tea/coffee making facilities. All lounge/dining rooms 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.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

##### 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 cleaning schedules in place. There is also a cleaning schedule/methods policy for cleaners. All laundry and personal clothing is laundered on-site. There are adequate linen supplies sighted in the facility linen store cupboards. There is a dedicated laundry person from 6am – 2pm daily. There is a defined clean/dirty area within the laundry which also has an entry and exit door. All laundry equipment has been tested and tagged March 2014. Chemicals are stored safely in the laundry area. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles. Safety data sheets are readily available. Laundry staff have attended training in chemical safety and on-site education such as safe manual handling and infection control. A sluice area and sanitizer is located within the dirty side of the laundry room and is accessible from the rest home and dementia care wing.
There is a dedicated cleaner for each of the services six hours per day Monday to Sunday. Cleaning trolleys are well equipped however there is an improvement required around chemical safety on the trolleys (link1.4.1.1). Trolleys are locked away in cleaning cupboards at the end of each day. Cleaning products are colour coded for example mop heads for each area. Personal protective equipment is available in the laundry, cleaning and sluice room. Staff are observed to be wearing appropriate protective wear when carrying out their duties. Seven residents interviewed (four hospital, three rest home) and seven family (four hospital, two rest home and one dementia care) are happy with the laundry and cleaning services provided.

##### 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:**

An approved fire evacuation plan is in place. Appropriate training, information, and equipment for responding to emergencies are provided. Mandatory staff training on fire safety was last held on 27 July 2014. Fire evacuations take place six-monthly with the last fire evacuation training on 27 July 2014.

There is a comprehensive civil defence manual and emergency procedure manual in place. Civil defence kits are stored securely.

The facility is well prepared for civil emergencies and has emergency lighting. An adequate store of emergency water is kept. There is a gas cooking for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available.

The hoist has a 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. 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 products such as incontinence products and personal protective equipment (PPE) are kept.

There is a store cupboard of supplies necessary to manage a pandemic.

The call bell system is currently being upgraded to an Austco system. Residents are able to use the current call bells system until the upgrade is completed. During a tour of the facility residents were observed to have easy access to the call bells in their bedrooms. Call bells are available in communal areas (e.g., lounges and dining areas). Residents interviewed stated their bells were being answered in a timely manner. A call bed audit is regularly conducted to monitor response times.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. All key staff hold current first aid certificates. At a minimum there is one person with a current first aid/CPR certificate available at all times.

##### 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 under floor heating and ceiling panels throughout the personal and communal areas. Bedrooms have additional heating provided (oil filled heaters) for individual residents as required. All communal rooms and bedrooms are well ventilated and well lit. Seven residents and seven family interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident’s rooms.

##### 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:** PA Low

**Evidence:**

The philosophy of the Bupa Restraint policy states 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated’.

There is a Regional Restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. Policy states that residents using an enabler must be able to voluntarily request the enabler.

The process of assessment and evaluation of an enabler and restraint use is in place. There were six residents on the restraint register who are using a restraint (bed rails and/or lap belts) and eight residents using an enabler (bed rails and lap belts). Two of these eight residents using an enabler in the form of bedrails and or lap belts were unable to voluntarily request the enabler. This is a required improvement.

There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, quality meetings, regional restraint meetings and at an organisational level. Staff receive annual education on restraint minimisation and safe practice. This includes staff completing a restraint competency questionnaire.

##### 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:** PA Low

**Evidence:**

The process of assessment and evaluation of an enabler and of a restraint is in place. There were six residents on the restraint register who are using a restraint (bed rails and/or lap belts) and eight residents using an enabler (bed rails and lap belts). Two of the eight residents using an enabler were unable to voluntarily request the enabler. Policy states that residents must be able to voluntarily request bedrails or laps belts.

**Finding:**

Two residents who were documented on the register as using an enabler were unable to voluntarily request the enabler, and therefore do not meet the criteria under Bupa’s definition of an enabler.

**Corrective Action:**

Ensure enablers are used only by residents who are able to voluntarily request the enabler.

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

A restraint approval process is in place. A job description for the restraint coordinator is in place. The restraint coordinator role is delegated to a registered nurse.

All staff are required to attend restraint minimisation training. The most recent training took place on 13 May 2014. Staff also complete annual restraint competency questionnaires.

##### 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:**

Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is in place, which meets the requirements of the standard. Care plans provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and resident’s family is also identified.

There are six residents (four hospital level and two dementia level) documented on the register as using an approved restraint (bed rails, lap belts, low beds) (link to finding 2.1.1.4).

##### 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:**

A Bupa restraint approval process is in place. Approved restraints are documented in policy. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plans identify specific interventions or strategies for trial before restraint use is implemented. Restraint authorisation is in consultation/partnership with the resident, family/whanau/EPOA, and the restraint coordinator.

The monitoring and observation process is included in the Bupa restraint policy. Each episode of restraint is monitored at pre-determined intervals depending on the individual risk to the resident. The restraint assessment and on-going evaluation of restraint use processes include reviewing the frequency of monitoring.

A restraint register is in place. The register identifies six residents (four hospital level and two dementia level) as using restraints (link to finding 2.1.1.4). Two of two resident files where restraint use has been implemented were selected for review. Appropriate restraint documentation was in place for both residents including assessments, consent, monthly reviews, evidence of regular monitoring where restraint was in use, and appropriate links to the residents’ care plans.

##### 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 residents on the restraint register, and as part of the care plan review. Families are included as part of this review. The restraint coordinator (RN) reports that the facility is actively engaged in reducing their number of residents using restraints. The files of two residents using restraints identified that the evaluations are up-to-date and have reviewed whether the desired outcome was achieved, whether the restraint was the least restrictive option and the impact of the use of restraint.

##### 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:**

Bupa is proactive in minimising the use of restraint. Three regional Bupa restraint groups are in place in New Zealand (Northern, Central North and Lower North – Southern). Each regional restraint group includes input and representation from individuals with appropriate expertise and experience. This includes a geriatrician, GM quality and risk, senior quality management coordinator, restraint coordinators from each facility and consumer and cultural representatives as needed. Meetings are held six-monthly. Objectives includes to ensure compliance with the restraint minimisation standard, to endorse and approve the policy and restraint methods to be used within the group ensuring the requirements of legislation, the restraint minimisation and safe practice standard, and current best practice are taken into account, to be informed and discuss all changed to organisational restraint practices, to undertake quality reviews of all restraint usage and to evaluate education in relation to restraint minimisation.

##### 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 is available. The infection control co-ordinator is a registered nurse based in the hospital wing who works across all shifts. There is a job description for the infection control coordinator (dated November 2013) with 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 are responsible for the development of the infection control programme and its review. The programme is not yet due for an annual review. There are quarterly infection control meetings that combine with the health and safety meetings. The quality meetings also include a discussion and reporting of infection control matters, trends and quality improvements. Information from these meetings is communicated to the registered nurse and staff meetings. Minutes and graphs are available for staff on the staff room notice boards.

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. There is a staff health policy.

The service has experienced two separate norovirus outbreaks (June and August) which included residents and staff that were managed. The service held a debrief/infection control training with the district health board infection control nurse following the outbreak. There are separate written reports for each outbreak that evidences appropriate authorities and families had been notified. Short term care plans for the management of individual residents are sighted in the resident files sampled.

##### 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 committee includes a cross section of staff from all areas of the service (kitchen, cleaning, laundry, activities, care staff, physiotherapy assistant), infection control co-ordinator, clinical manager and home care manager. The facility also has access to an infection control nurse at the district health board (DHB), public health, GPs, laboratory 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:**

D19.2a: 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.

##### 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. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control questionnaires and hand hygiene checklist. The infection control coordinator (registered nurse) attended an infection control day provided by the Southland DHB a year ago.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza and norovirus.

##### 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 (RN) 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. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the care home 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.)*