

Bupa Care Services NZ Limited - Kauri Coast Hospital & Rest Home

Current Status: 11 September 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Kauri Coast Hospital and Rest Home is owned and operated by the Bupa group. The service is certified to provide hospital (geriatric and medical) and rest home level care. The service has approved capacity for 52 residents. Since the previous certification audit the service has built an additional four single bedrooms onto the end of the rest home wing. These four bedrooms have full ensuites giving a total of 14 bedrooms that can be used for either rest home or hospital level residents. The facility can accommodate up to 36 hospital level residents although all bedrooms throughout the facility are spacious and easily able to accommodate hoists and hospital beds.

On the day of the audit there were 23 hospital level residents, and 18 rest home level residents. Kauri Coast Hospital and Rest Home has had a recent change in care home manager (previously referred to as the facility manager) and a change in clinical manager. Both managers are currently orientating to their roles and being supported by the operations manager and head office staff.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service including residents that require hospital, medical and rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to the facility.

The service has addressed all three of the three shortfalls identified during their previous certification audit, which were related to short term care planning, documentation of medicine management and the education of the infection prevention and control coordinator.

Audit Summary as at 11 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

Indicator	Description	Definition
	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 11 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.		Standards applicable to this service fully attained.
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Organisational Management as at 11 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 11 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 11 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.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 11 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 11 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.
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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 - Kauri Coast Hospital & Rest Home
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Kauri Coast Hospital & Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 September 2014 End date: 12 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:	41

Audit Team

Lead Auditor	XXXXXX	Hours on site	15.5	Hours off site	8
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	2

Sample Totals

Total audit hours on site	15.5	Total audit hours off site	10	Total audit hours	25.5
Number of residents interviewed	6	Number of staff interviewed	7	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	42	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Wednesday, 1 October 2014

Executive Summary of Audit

General Overview

Kauri Coast Hospital and Rest Home is owned and operated by the Bupa group. The service is certified to provide hospital (geriatric and medical) and rest home level care. The service has approved capacity for 52 residents. Since the previous certification audit the service has built an additional four single bedrooms onto the end of the rest home wing. These four bedrooms have full ensuites giving a total of 14 bedrooms that can be used for either rest home or hospital level residents. The facility can accommodate up to 36 hospital level residents although all bedrooms throughout the facility are spacious and easily able to accommodate hoists and hospital beds.

On the day of the audit there were 23 hospital level residents (including one hospital level respite person with one hospital level resident being cared for in a neighbouring hospital and due for readmission). There were 18 rest home level residents (including one resident on rest home level respite care).

Kauri Coast Hospital and Rest Home has had a recent change in care home manager (previously referred to as the facility manager) and a change in clinical manager. Both managers are currently orientating to their roles and being supported by the operations manager and head office staff.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service including residents that require hospital, medical and rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to the facility.

The service has addressed all three of the three shortfalls identified during their previous certification audit, which were related to short term care planning, documentation of medicine management and the education of the infection prevention and control coordinator.

Outcome 1.1: Consumer Rights

The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Policies are implemented to support resident rights such as the right to be fully informed and to make an informed choices and the right to complain. Information about the Code is readily available to residents and families. Complaints processes are implemented. Residents and family interviewed verified that staff contact them if there is a change in the health status of their relative and all spoke positively about care provided.

Outcome 1.2: Organisational Management

Kauri Coast Home and Hospital is governed by the Bupa Group. Both the home care manager and the clinical manager are new appointees to their roles. They are in the process of being orientated and there are excellent support systems in place for them. Bupa has a business plan in place and the facility operates a quality plan which includes goals for the calendar year. The service operates an established quality and risk

management system that is integrated in planning and overseen by the quality and risk team at head office and local management. An annual resident and/or relative satisfaction survey is completed and there are regular resident/relative meetings. Adverse event reporting occurs and staff communicate events to relatives where appropriate. Quality and risk performance is reported at facility level at meetings and displayed on staff notice boards. Key quality indicators are benchmarked with other Bupa operated facilities operating rest home and hospital services throughout New Zealand and results are regularly communicated to the facility. The systems for quality and risk management are continually being reviewed at both an organisational level. There are established human resources policies and procedures in place. New staff are provided with a comprehensive orientation programme. There is an in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are appropriate for the level of service provided.

Outcome 1.3: Continuum of Service Delivery

The facility has a comprehensive range of service policies, associated procedures and forms to guide staff. Service information is made available to consumers and their family prior to entry. Registered nurses are responsible for each stage of service provision. Service provision meets required timeframes. There are established systems to assess, plan and evaluate care needs of residents. Residents are reviewed on a regular basis with the resident and/or family/whanau input. An improvement required around aspects of care planning documentation was identified during the previous audit and has since been addressed.

Medicine management follows policy. An improvement was identified at the previous audit regarding documentation of the route of administration of medications. This shortfall has been addressed.

The activities programme is facilitated by an activity co-ordinator. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged. Van outings are arranged on a regular basis.

The majority of food is prepared and cooked on site. Meals are cooked according to the nationwide dietitian approved menu plan. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented. Consumers and relatives expressed satisfaction with the menu.

Outcome 1.4: Safe and Appropriate Environment

The building has a current building warrant of fitness. Four single bedrooms with ensuites have been built since the previous certification. There is a Code of Compliance certificate for these additions. There is an approved evacuation scheme in place and the Dargaville Fire Service advised that the current evacuation plan does not need further amendment with the addition of these four bedrooms.

Outcome 2: Restraint Minimisation and Safe Practice

Restraint usage is minimised wherever possible in accordance with company philosophy. Residents are able to use enablers. There is a restraint minimisation policy that includes definitions and outlines comprehensive restraint procedures. The service is using bedrail restraints for two residents and five residents are using bedrails as enablers. Restraint assessments are based on information in the care plan, discussions

with residents and on staff observations of residents. Restraint and enabler usage is reviewed for each individual resident at least three monthly and as part of their six monthly multidisciplinary review. Reviews include family/whanau where appropriate. Restraints and enablers are also reviewed at an organisational level and usage is benchmarked between facilities. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control co-ordinator role has been taken up by the newly appointed clinical manager who is a registered nurse with a specialist background in infection prevention and control. She is responsible for coordinating the surveillance aspects of the programme and is supported by the Bupa quality and risk team. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. A previous shortfall, which was related to the education of the previous infection prevention and control coordinator, was addressed. That staff member has since resigned.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	18	0	0	0	0	0
Criteria	0	48	0	0	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	32
Criteria	0	0	0	0	0	0	0	53

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

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

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

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

Attainment and Risk: FA

Evidence:

The service provides an environment which enables effective communication with residents. This includes full information at entry and open disclosure. Management contact relatives and discuss matters in an open manner consistent with the open disclosure policy. The accident/incident forms have a section to indicate if family/whanau have been informed (or not) and the name of the person informed. Staff record contact with family/whanau on the family/whanau contact record.

Nine of fifteen accident/incident forms reviewed for August 2014 identified that family were notified when the incident occurred. The difference is because families often give instructions to staff regarding whether they want to be contacted when certain types of accident/incidents occur and these instructions are documented in the resident's file.

Residents are orientated to the service on admission. Informed consent processes are in place. Residents have access to interpreter services which includes access to the Blind Foundation and the Hearing Association.

A 13.1 & D 13.2: Each resident or their nominated representative is provided with an admission agreement and a copy is stored onsite in the administration office.

A 14.1: The Admission Agreement references exclusions from the service. D 11.3: The information pack is easy to read and if needed the information can be read to residents and is available in large print.

D12.1 & D12.3a: 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.

D 12.4 & D12.5: Residents (and/or their representatives) are informed in the agreement of their right to apply for a review of their means assessment

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

D16.4b: Relatives are notified as soon as staff become aware that a resident's health has changed significantly (confirmed in discussions with the clinical manager and two of two relatives (one rest home and one hospital).

D 16.5e, iii: On-call emergency services are available and the costs are met.

The content of the admission agreement was checked at the request of the DHB to ensure that the requirements for ARRC Clause 5.1 are met ensuring that "private payers" who have been needs assessed are not charged for services which are covered by the ARRC Agreement (ie including GP visits (D16.5), transportation to services (D20),

supplies such as pharmaceuticals, wound dressing and continence supplies (D18)). The admission agreement reflects that “private payers” are not charged for services under the ARRC Agreement.

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

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

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

Attainment and Risk: FA

Evidence:

There is a documented complaints policy and associated procedure that complies with Right 10 of the Code. The complaints process is easily accessible to residents and family members. Complaints are logged in a complaints register, which is manual on site and complaints are also recorded electronically. The register is maintained in monthly format at the facility. It is up-to-date and includes all complaints, dates, and actions taken. Complaints are managed locally with head office oversight to ensure all complaints are managed appropriately. All allegations are actively investigated by the Care Home Manager. Management have access to a number of template response letters to ensure documentation complies with the Code. There are six monthly external compliance audits to ensure on-going compliance to the documented complaints process (last internal audit of client rights was conducted in June 2014). Staff are aware of the complaints policy and can correctly articulate their responsibilities (confirmed in discussion with the clinical manager, two of two registered nurses, one enrolled nurse and two of two caregivers).

Copies of complaints were sighted (both hard copy complaints and entries on the complaint register). Justified complaints have been actioned.

All complaints received since February 2013 were reviewed. Bupa has a policy of recording all expressions of dissatisfaction irrespective of complainant and therefore the total number of complaints reported can exceed the true number of consumer complaints as defined by the Code. Of the 24 complaints received year-to-date, 17 of 24 (ie, 71%) related to the food service, five related to communication issues and two were anonymous issues that were lodged directly with the DHB. The two anonymous complaints were found not to be justified following investigation. All complaints contained documentation of the investigation, corrective actions if required, resolution and feedback to the complainant. Staff had refresher training on appropriate communication on 27 August 2014. First impressions training on perceptions was given on 20 August 2014. Training on the Code was last held 8 July 2014.

Resident satisfaction with meals is monitored daily by way of a feedback chart, which is situated directly outside the dining room. A review of this chart showed that residents had documented many compliments this calendar year. The facility scored 82% resident satisfaction with meals in the latest annual satisfaction survey completed in June 2013. The cook is aware of the issues that some residents have with the food service. She is of the opinion that there are occasional flare ups by a few residents who have particular views about food and she tries to accommodate their wishes were known in advance. Management are aware. Residents and relatives interviewed spoke highly of the food service (confirmed in discussions with six of six residents (three rest home and three hospital) and two of two relatives (one rest home and one hospital). The food service was observed to be consistent with the menu and appropriate during the two audit days). The 2013 satisfaction survey showed that 84 percent of respondents were overall satisfied with the food services provided.

D13.3h. The complaints process is provided to resident/relatives at entry to the service and is also prominent around the facility on noticeboards. Discussion with six residents (three rest home and three hospital) and two family members (one rest home and one hospital), confirmed they were provided with information on complaints and complaints forms.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Services are provided for up to 52 residents of which 14 can be used for either rest home or hospital level residents. At the time of the audit, there were 18 rest home level residents (including one respite resident) and 23 hospital residents on site (including 1 respite). An additional two hospital residents were offsite being cared for in hospital.

Kauri Coast Home and Hospital has been owned and operated by Bupa Care Services NZ (Bupa) since 27 September 2010. Bupa's head office is based in Auckland. There is a three year strategic plan in place covering 2012 to 2015 (sighted), which is available on the Intranet. The plan identifies the overall objectives of the business. There is an overall Bupa business plan and risk management plan in place and an annual quality plan in place for Kauri Coast which includes specific quality goals.

The care home manager (previously known as the facility manager) is a recent appointment who commenced 18 August 2014. He is a non-practising NZ registered nurse who has worked in the health and disability sector for 19 years. He has the authority, accountability, and responsibility for the provision of services (confirmed in review of the job description for the position and in discussion with him as his employment records are held offsite in Auckland). He is supported by a full-time clinical manager who is a recent appointment who commenced in the role on 28 July 2014. The clinical manager is a practising registered nurse who was employed by a district health board prior to appointment (employment records reviewed). Both managers are supported by the Bupa executive team and the operations manager was onsite during the audit.

Bupa has robust quality and risk management system in place which is standardised and implemented across its facilities. The system is monitored closely by head office. 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 quality monitoring programme includes six monthly compliance audits on a rolling programme by the organisation's management, which is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Non-compliance for these audits result in corrective action plans which are monitored by head office staff.

A18.1; There are sound financial management systems in place which are coordinated from head office.

A27.1; There is comprehensive insurance covering the business throughout the term of the Agreement.

A30.1; Kauri Coast does not assign any service delivery to another provider.

D5.1; D5.2; D5.3; There is a range of policies and procedure in place to guide the provision of services (both electronic and hard copy).

D17.3di (rest home), D17.4b (hospital), there is a least one registered nurse on duty at all times (confirmed in discussion with two of two registered nurses, the enrolled nurse (who is the unit coordinator in the rest home) and two of two caregivers). The care home manager is experienced in management and is a registered nurse without a current practising certificate (D17.5). The care home manager has just completed 16 hours of professional development activities related to managing a hospital. The clinical manager is a practising registered nurse who has been orientated to the role and is scheduled to attend additional management education through Bupa this year. Both managers are supported by eight registered nurses and they have access to support from the head office. 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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Kauri Coast Hospital and Rest Home utilises the well-established Bupa quality and risk management system. The quality and risk management system is outlined in the quality manual. The plan is understood and implemented by staff. The plan is monitored by head office and the Care Home Manager reports weekly to the Operations Manager on progress and any issues.

There are policies and procedures which are developed by head office quality and risk team to match current good practice and relevant contractual and legislative requirements. Policies are reviewed at least every five years or earlier if there is a change in process (ie, legislation or practice necessitating review). The review period is documented in the document control policy. Documents are approved, up to date, available to staff and managed by quality and risk at head office to preclude the use of obsolete documents.

Key components of the quality and risk management system include resident satisfaction, adverse event reporting, health and safety, infection prevention and control, and restraint minimisation.

Quality improvement data are collected, analysed, evaluated and results communicated to staff, and where appropriate consumers. Results are communicated to head office for review and benchmarking between Bupa sites. Kauri Coast staff implement corrective action plans where opportunities for improvement are identified. Data are collected for all adverse events, hazards, infections (actual and potential), resident weights, medicine errors, wounds, the use of restraints and enablers, and resident satisfaction. Data, analysis and trends are discussed at facility meetings and trend graphs for all quality data are placed on the staff notice board for all staff to see (sighted). This is well documented for the quality meeting held 12 August 2014.

The care home manager reports to the operations manager weekly against the facility quality plan and any adverse events or potential risks.

There is an annual internal audit programme in place which is overseen by head office. Internal audit results are reported through to head office and results are displayed in the staff room to inform the team. Opportunities for improvement are identified and actioned if compliance is less than 100%.

Actual and potential risks are identified, monitored, analysed and reviewed. There is a hazard register in place. 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. 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.

Resident and family satisfaction is monitored annually. The 2014 satisfaction survey showed that 85 percent of respondents were overall satisfied with the services provided.

There are regular resident and family meetings held (confirmed in discussions with six of six residents (three hospital and three rest home) and two of two relatives (one hospital and one rest home). Minutes are maintained (minutes sighted for February, April and June 2014). Issues raised are documented and followed up and reported at the next meeting. Corrective action plans are implemented for areas requiring improvement.

Staff confirm that they are kept up to date with quality data, trends and any required corrective actions (confirmed in discussions with two of two registered nurses, 1 enrolled nurse, and two of two caregivers).

A4.1: There are a range of policies in place.

D1.1 & D1.2; Managers are aware of the need to comply with relevant legislation.

D5.4: All policies as listed in the Agreement exist to guide staff

D10.1: There is policy in place to guide staff in the expected and unexpected death of a resident.

D17.7a, b, e; RNs are required to demonstrate competencies prior to performing tasks, procedures or treatments. The Clinical nurse manager holds a competency assessment register which records all care staff competencies and the date achieved (Excel spreadsheet sighted). Competencies include, drug administration including controlled drug administration, phlebotomy, nebuliser use, BSL recording and Insulin administration, Wound management, Oxygen administration, syringe driver use, giving of sub-cutaneous fluids, restraint management, and hoist use. There are policies in place to guide staff in managing clinical and non-clinical emergencies.

D19.1, 2, 3, 4 & 5: There are established quality and risk management systems in place which include a quality assurance programme and a quality improvement programme.

D19.2g fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. A physiotherapist conducts assessments of all residents and develops mobility plans for those residents who require such plans. Sensor mats are in use.

D19.3 There is a comprehensive health and safety and risk management programme in place. There is a Bupa Health & Safety Plan in operation across all sites. Policies are implemented and monitored by the monthly quality meetings. Risk management, hazard control and emergency policies and procedures are in place. The organisation's benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p>

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.3a.vi: There is a system in place to manage accidents incidents and hazards. Staff complete an accident/incident form which is given to the registered nurse in charge on the floor. The registered nurse actions the event as appropriate which includes contacting family and then forwards the form to the clinical manager for her attention and then care home manager. The form is then forwarded to the care home manager. A duplicate is made of the form for quality management purposes, which is held by the clinical manager. The original document is filed and noted in the list of events in the resident's clinical record file. Any corrective actions are identified is actioned. The clinical manager and the home care manager report on the collective data monthly. There is a hazard register in place displayed in multiple places throughout the building (sighted).

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

D19.3c: The key risks of theft/burglary, fire, accidents & incidents, chemical incidents and disposal of waste are noted.

Management understand their requirements in regard to essential notification reporting. The process in place is that care home manager will contact the operations manager or the quality and risk systems coordinator if the event is determined to be Category 1 event as defined in policy.

There is an open disclosure policy in place to guide staff. Family members' report they are informed of changes in their relatives health status (confirmed in discussions with two of two relatives (one hospital and one rest home).

All accident/incident forms for August 2014 were reviewed. Of the 15 forms completed family were contacted in nine of fifteen events. The difference occurs because sometimes family are present during the event and other families have left instructions to staff regarding whether they want to be contacted or not when certain types of accident/incidents occur. Communication instructions are documented in each resident's file. All 15 of 15 forms included documentation to demonstrate the event was well managed and appropriately reviewed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa has a standardised system of human resource management in place which is implemented at Kauri Coast. There are a range of human resource policies in place covering recruitment, appointment, orientation, education, performance management, and exit management. There is a process of reference checking, checking of qualifications, Police record checking, ensuring health practitioners maintain current practising certificates (which are monitored on an on-going basis by the care home manager who holds copies of current practising certificates) (sighted).

Five staff files were reviewed of staff interviewed which included the employment records of the clinical manager, the hospital unit coordinator who is a registered nurse, two caregivers (one newly appointed and one who is medicine competent) and a cook. All five staff files document appropriate employment practice (eg; all five of five staff have a signed contract of employment, a job description matching their position, records of qualifications, records of orientation and on-going education).

There is a documented training and education procedure that describes the organisation education programme. The organisation conducts both mandatory training and site specific training. Training is a component of the competency based pay scale. There is a training programme in place for the 2014 calendar year. Opportunistic education is provided by way of tool box talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care (eg; wound management and

catheterisation). External education can be accessed through the DHB if required. Details of training sessions are retained and logs of training for individual staff are maintained. Attendance at training sessions is good. Registered nurse competencies are overseen by the clinical manager. Registered nurses participate in the Bupa PDRP system for recognition of professional development.

D17.6: All newly engaged staff receive an orientation (confirmed in review of five of five staff files and in discussions with the two newly appointed managers).

D17.7: Registered staff are required to demonstrate competencies in medicine management, wound management and other technical skills needed by residents.

D17.7d: Registered nurse (RN) competencies include but are not limited to: assessment tools, Blood sugar levels (BSL)s/Insulin administration, Controlled Drug administration, moving & handling, nebuliser, oxygen admin, restraint, wound management and T34 syringe driver.

D17.8: There is an on-going programme of staff development. Caregivers are strongly encouraged and financially incentivised to complete CareerForce Training (confirmed in discussions with two of two caregivers). Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a staffing rationale policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing ratios are monitored by head office. The manager advised that staff are very stable with a low turnover. Clinical staff are managed by the clinical manager. Both the hospital and rest home area each have a unit coordinator who reports to the clinical manager. The hospital unit coordinator is a registered nurse and the rest home unit coordinator is an enrolled nurse who works under the supervision of a registered nurse. There are a team of registered nurses employed to ensure that there is always a registered nurse on duty. Staff interviewed (ie, the clinical manager, two of two registered nurses, one enrolled nurse (rest home area coordinator) and two of two caregivers) reported that the levels of staff providing clinical care at any one time are appropriate. Staff work in teams of two primarily in each wing as many residents require two staff to transfer them to or from their bed or chair. There is registered nurse cover across the facility over each 24 hour period. Each morning in the hospital wing there is typically one registered nurse and two caregivers on duty and the rest home wing is staffed by one enrolled nurse and two caregivers as this wing now has a mix of hospital and rest home level residents and rest home level patient acuity has increased over the years. The afternoon shift is typically staffed by one registered nurse with two caregivers on duty in both the hospital and rest home wings. The night shift is staffed by one registered nurse and at least one care giver depending on acuity. The care home manager and clinical manager are on-call if needed.

Residents believe that staffing numbers and response times to requests for assistance are appropriate (confirmed in discussions with six residents (three hospital and three rest home) and two of two relatives (one hospital and one rest home)).

The service contracts with allied health professionals on an "as required" basis, which currently includes a contracted physiotherapist who attends for 2 to 3 hours a day from Monday to Friday.

D17.1; Management are aware that they must provide sufficient staff to meet the health and personal needs of residents.

D17.3 (Rest Home) and D17.4 (Hospital). Management are aware of the need to ensure the facility has the correct management structure in place and that there is a registered nurse on duty at all times.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; 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:

D4.1 (d) & (e): Service delivery involves the resident and their family where appropriate in the decision making process (confirmed in discussions with the clinical manager, two of two caregivers, and the enrolled nurse).

D16 5(a): Services are provided in a timely manner by staff at times that are consistent with community norms and all care is overseen by registered nurses.

There is an implemented admission role of caregiver policy, an admission role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.

D16.2, 3, and 4: The five files reviewed (two rest home and three hospital), identified that in all five files an assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks of admission. There is documented evidence that care plans are reviewed by a registered nurse and amended when the resident's current health changes. Evaluations are completed at least six monthly.

Activity assessments and the activities sections in care plans have been completed by an activities coordinator. All residents have at least an initial physiotherapy assessment with on-going assessments as necessary.

Six residents interviewed (three hospital and three rest home) stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files reviewed (ie two rest home and three hospital) included records of communications with family or family participation in decision-making related to care.

D9.1 & 2 there is a handover at commencement of each shift and each carer receives a report on the status of the residents that they are required to care for. The report is based on the care plan, which is available to all staff. Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

D16.5e: Five resident files reviewed identified that the general practitioner had seen the resident within two working days. There are two general practitioners who visit the facility at least twice a week or can visit more frequently if needed. The GPs either assess the resident as stable (and if so they will be seen at least three monthly) or they see them more frequently (ie, at least monthly). Some residents are seen weekly.

A range of assessment tools are completed using Bupa templates and the assessment booklet. Assessments are completed in on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment.

Documentation is integrated and a team approach is evident. Registered nurses take responsibility for coordinating the care for a number of individual residents. The GP interviewed spoke very highly about the service and described an effective communication process. He reported that the registered nurses will often telephone him to discuss residents if they have concerns and if necessary a general practitioner from the local general practice will visit.

Tracer Methodology:

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

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

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

Attainment and Risk: FA

Evidence:

Residents' lifestyle care plans are completed by the registered nurses. Short term care plans are implemented when necessary and there is a register listing all short term care plans maintained in each nursing station to ensure there is no breakdown in communication and to provide ease of oversight by the clinical manager. Short term care plans are linked to the resident's long term care plan and integrated when appropriate. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all five of five residents' files). When a resident's condition alters, the registered nurse initiates a review and if required, a visit from the general practitioner and if needed a specialist consultation and at times a short term care plan is commenced. Staff (ie; two of two caregivers and the enrolled nurse), believe they have all the equipment referred to in care plans and necessary to provide care, including hoists, transfer belts, wheelchairs, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies.

All six of six residents (three hospital and three rest home) and two of two family members (one rest home and one hospital) were complimentary of the care received at the facility.

D16.3 (a) Each resident has a care plan (confirmed in review of five of five residents' files (two rest home and three hospital).

D 16.3 (e) g to l) Each care plan considers the resident's needs and preferences.

D 16.5 (e) (i) Each resident is examined by a general practitioner within 2 working days of admission and a summary of their examination notes is recorded. Thereafter they are re-examined at least monthly unless the resident's medical condition has been assessed as stable in which case they are seen at least every three months.

D18.3 and 4 Dressing supplies are available and a treatment room is well stocked for use. Wound assessment and wound management plans are in place for 13 residents in the hospital and rest home areas who between them have a total of 29 wounds (which include 11 pressure areas (one grade four), 17 skin tears and one old stoma wound which requires a dressing and oversight). There is a monthly wound log maintained in each area.

The registered nurses are able to refer to wound nurse specialists or continence nurses. 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. Wound management in-service has been provided. Staff training on wound management occurred in May 2014. The facility has continuous registered nurse cover and has a comprehensive 'in service' education programme in place. Toolbox talks on areas identified as special interest occur. During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents and families were able to confirm this observation.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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:

D16.5 c iii: Each subsidised resident has a written and implemented activities programme, which is developed within the initial weeks of admission following an assessment which includes staff obtaining a complete history of the resident's past and present interests and life events. Their participation in the activities programme is reviewed six monthly as part of the resident's multidisciplinary review (confirmed in review of five of five residents records (two rest home and three hospital).

D16.5d: The activities programme includes group and individual activities and involvement with the wider community.

A record of each resident's participation in the activities programme is maintained by the activities staff and a record is maintained in their clinical record.

There is an one activity co-ordinator who is employed full-time five days a week to cover both rest home and hospital level residents (interviewed). The activities coordinator provides one combined group programme for any resident who wishes to participate. Only one programme is offered because most residents have similar cognitive ability. The group programme is provided in differing areas throughout the facility to increase stimulation. On the day of audit residents in all areas were observed being actively involved with a variety of activities. The group programme is developed monthly and weekly programmes are displayed in large print throughout the facility. The programme includes networking within the community with social clubs, churches and schools. The programme includes cognitive stimulation activities (eg, newspaper readings, doing puzzles, crosswords, paying bingo), physical stimulation (eg; exercises, floor bowls, garden walks, van rides to the community) and socialisation events (eg happy hours, singing, birthday celebrations, and cooking events) and church services are held onsite. Participation in all activities is voluntary.

Six residents (three hospital and three rest home) and two family members (one rest home and one hospital) stated they were happy with the activities programme and that residents were given choice regarding participation. Resident satisfaction in the 2013 Satisfaction Survey showed that 82 percent of respondents believed the activities programme was meaningful.

Residents meetings occur two monthly (minutes sighted for February, April and June 2014)

The facility has its own van with wheelchair access (12 seater and hoist capable) Van outings occur at least twice a week weather permitting. The activities co-ordinator has a current first aid certificate and is a recognised driver of the van

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:

Resident centred care plan evaluations are up to date. Six monthly evaluations or earlier occur if a resident's health changes (confirmed in discussions with six of six residents (three hospital and three rest home) and two of two family members (one hospital and one rest home). Evaluations are completed by the registered nurse with input from the general practitioner, caregivers, the activities coordinator, the resident and family if available, and any other relevant person (eg, physiotherapist) involved in the care of the resident (confirmed in discussions with the general practitioner, the clinical nurse manager, the enrolled nurse, two of two caregivers and the activities coordinator. The activities plan is reviewed at the same time. A written Multidisciplinary Review (evaluation) is completed against the long term care plan's desired goals and progress/achievement towards the goals are recorded. Short term care plans are used and evaluated, resolved or added to the long term lifestyle care plan if the problem is on-going. Short term care plans are used for acute problems.

The certification audit identified that short term care plans were not being completed when there was a change in a resident's condition. Short term care plans are maintained in resident's clinical record and there is a folder which contains all active short term care plans. The contents list in the folder contains details of all short term care plans in use and lists the date resolved or transferred to the resident's long term care plan. The clinical manager performs clinical file audits to ensure documentation occurs according to policy (last internal audit completed 19 August 2014 which showed 93 percent compliance in a sample of 10 clinical records). The documentation audit of clinical files form used for individual auditing includes monitoring of short term care plans. The clinical manager also monitors the active short term care plans in place. Short term care plans are being used when there is a change in a resident's condition (confirmed in review of five of five clinical records and in review of the short term care plan folder). This is an improvement from the previous audit.

D16.3c: All initial care plans are evaluated by a registered nurse within three weeks of admission.

D 16.2 d: All care plans are reviewed by a registered nurse and amended where necessary to address current needs

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

D 16.3 (K) Short term care plans are documented in a plan which is linked to the care plan. Short term plans are used in a variety of situations which include wounds, infections, skin conditions, and the onset of frequent falling.

D 17.3 (e) (i) (2) (3) & D17.4 (c) (iv). Residents are assessed on admission, when their health status changes or their dependency needs change or at least 6 monthly. There is an on-going reassessment of care plans.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.12: 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:

There are policies and procedures in place to guide staff on medicines management. All medicines are charted by the residents' GP (confirmed in review of ten of ten medicine charts (five hospital residents and five rest home residents). The facility has a contract in place for medicine supply with a local pharmacy. Tablets are packaged using the robotics system. Non-tablet medicines are supplied in pharmacy labelled containers. Staff have access to online medicines information from the pharmacy, the GP and Med Safe. Medicines are administered by a mix of care staff including registered nurses, the enrolled nurse and caregivers on each shift who have been assessed as competent by registered nurses who have been assessed as competent (observed during a medicine round and confirmed in discussion with the clinical manager, and two of two caregivers who work in both the rest home and hospital area and in review of employment records). Their competency to administer medicines is assessed by a competent registered nurse who has been assessed as competent by another registered nurse who is employed at the DHB. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medication management training was held in September 2014 and eight staff attended.

Warfarin administration occurs and is being well managed according to Bupa policy which was developed in consultation with a DHB.

Staff are able to use a small number of standing orders according to Bupa policy. There is a list of standing order medications that have been approved by a GP. The GP reports that most staff tend to use verbal orders rather than standing orders and will telephone him in the first instance to discuss the resident's change in condition prior to administering medicines.

Three residents were self-administering medicines (one was injecting insulin). Staff are following policy in relation to the self-administration of medicines. Residents who are self-administering medications were evidenced to have had a competency assessment completed which is reviewed by GP and registered nurse three monthly. Resident were storing tablets securely in their rooms.

The GP conducts reviews of residents three monthly to ensure medicine supply and this date is recorded in the medicine record. The registered nurses use a diary system to ensure compliance is maintained. A general practitioner visits the facility routinely every Tuesday and Friday and will come anytime they are needed. There is one treatment room on the hospital side and one nurse's station on the rest home side. There are two custom built medicine trollies in use (ie, one for each wing). Medicines requiring refrigeration are stored in refrigerator in the hospital wing treatment room. Controlled drugs are individually prescribed and packaged and stored in the nurses' station in the hospital wing. Two competent staff members check out the controlled drugs. A six monthly pharmacy audit is completed. Medicines no longer required are quarantined and returned to the pharmacist. Medicine reconciliation occurs when patients are admitted with medicines (eg, respite residents) All medicines received in the facility are checked by the registered nurse on arrival. Any discrepancies would typically be documented and the error fed back to the pharmacy (There have been no discrepancies noted since the previous audit). Staff sign the Douglas Pharmaceuticals designed medicine administration charts which are produced by the pharmacy. Staff then initial once they have administered a medicine to a resident.

Ten of ten medicine charts (ie, five hospital and five rest home) were sampled for review. All ten of ten charts included recent photo identification, indications of allergies/adverse reactions, and any special instructions for administration on the medicines chart. The prescribing met legislative requirements. The signing sheets were correctly signed and PRN medications are correctly charted, dated and timed on administration.

The findings from the previous audit relating to a) medication charts not documenting the route of administration, and medication signing incidents not being documented on incident forms have now been addressed. Medicine related incidents are being recorded as accidents or incidents (confirmed in review of all accidents and incidents this calendar year which demonstrates that staff have documented six medicine related incidents which have been investigated). The pharmacy generated forms list the route the medicines are to be administered. These shortfalls have been addressed.

D16.5: All 10 of 10 medicine charts sampled identified that the GP had seen and reviewed the resident at least three monthly and the resident's medicine chart was signed accordingly.

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): (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:

The facility employs one head cook (interviewed) who works fulltime and she alternates shifts with another second cook. They prepare all three main meals and snacks according to the national menu. The menu policy (315) states that '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'. The national menus have been audited and approved by an external dietitian. The menus were last reviewed in March 2013.

The kitchen supplies meals for the hospital and rest home residents. All of the kitchen team at Bupa Kauri Coast Hospital and Rest Home have completed food safety certificates. The cook is involved in Quality Health and Safety and Infection Control committees. Food for Thought meetings occur monthly and include discussion of residents' specific dietary needs.

Meals for residents in the hospital are plated up by kitchen staff and staff pick up and deliver to the hospital wing using insulated plate covers in a Scan box delivery system to keep the food hot.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Residents participate in a post-admission survey conducted after six weeks. and an annual satisfaction survey. Comments from resident feedback are displayed in large print on the rest home dining room noticeboard. There are a number audits completed include; a) Kitchen audit, b) Environment kitchen, c) Catering service survey, food safety/storage and d) Food service audit.

Residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook. Special diets are noted on the kitchen notice board which is able to be viewed from within the kitchen area. Special diets being catered for include soft diets, puree diets, weight reduction and a 'diabetic diet' which is an adjustment on the main menu applying a common sense approach.

Residents and family report satisfaction with food choices and the food service (confirmed in discussions with six of six residents (three hospital and three rest home) and two of two relatives (one hospital and one rest home). Meals are well presented (observed) and alternative meals are offered as required. The resident satisfaction survey carried out in 2013 recorded 87 percent satisfaction with the food service. A Feedback folder was evidenced on a table at the entrance to the dining room in the rest home in which residents have written in their comments regarding their meals and the food service. The folder also evidenced the cook's responses to comments made by residents. The majority of comments were complimentary. A food service audit was conducted in July 2014 which was satisfactory.

D19.2 staff have been trained in safe food handling.

D15.2 (b) There is a food service that ensures residents are provided with adequate and nutritious meals, refreshments and snacks at times that reflect community norms, take account of likes and dislikes, and meets the nutritional requirements of older persons.

The Cook reports that the kitchen stocks at least three days' supply of food to assist them in emergency management should supply be disrupted.

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.

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p>

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 1.4.2: 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:

There is a current building warrant of fitness which expires 3 Sept 2015. Four bedrooms were added on to the premises in 2014 (link 1.4.7). A Code of Compliance Certificate (130266) was issued on 9 April 2014 by the Kaipara District Council for the alterations and additions.

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 1.4.7: 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:

There is an approved evacuation plan dated 13 April 2000. The Fire Safety Officer from the Whangarei Fire Service stated by telephone on the day of audit that there was no need to change the current evacuation plan as there was only an addition of four rooms and not another wing. The additional four bedrooms are located within fire zone 4. There are internal fire stop doors to the zone and an external fire exit to the external ramp. Staff are provided with on-going fire and emergency management training (last provided 12 August 2014). Alternative gas energy is available in the event of the main electricity supply failing. There is an electronic call bell system in place throughout the facility. There are security arrangements in place to manage resident safety.

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.)*

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint practices are overseen by the restraint coordinator who is a registered nurse. Restraints are only used where they are clinically indicated and justified and other de-escalation strategies have proved ineffective. Policies and procedures are comprehensive; include definitions, processes and the use of enablers. Enablers are voluntary and the least restrictive option is used for restraint. There are five residents using enablers (all bedrails) and two residents have restraints (both bedrails). The restraint files were reviewed and included consents, assessments and on-going reviews.

Staff are trained in restraint minimisation and safe practice (last education provided September 2013 attended by 27 staff). Education is given individually by the restraint coordinator who personally checks staff competencies individually. A record is kept in the personnel records and an electronic competency database.

The internal compliance audits and the monthly quality reporting process monitor each facilities' restraint use (last audit September 2013). There is a Regional Restraint group at an organisation level that reviews restraint practices.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Standard 3.4: 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 previous certification audit identified that the infection prevention and control coordinator had yet to complete external training. This person has since resigned and has been replaced by the clinical manager who prior to this appointment was employed as a clinical nurse specialist in infection prevention and control by a DHB. She reported that she provided training to the previous incumbent to correct the area of concern when she was employed by the DHB. This is an improvement from the previous audit.

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:

Bupa's infection prevention and control committee determines the type of surveillance required and the frequency with which it is undertaken. This is outlined in the surveillance policy, which describes and outlines the purpose and methodology for the surveillance of infections. The infection prevention and control coordinator is the newly appointed clinical manager who is experienced in infection prevention and control having worked as a clinical nurse specialist for infection prevention and control in a number of DHBs prior to her appointment. The infection prevention and control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This information is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection prevention and control co-ordinator and forwarded to head office. Definitions of infections are in place appropriate to the complexity of service provided. Infection prevention and control data are collated monthly and reported at the quality, and infection prevention and control meetings. The infection control programme is linked with the quality management programme. The results are subsequently included in the report on quality indicators returned to the facility by head office. Internal infection control audits also assist the service in evaluating infection control needs (last internal audit was conducted June 2014). 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. The facility last had a major outbreak (norovirus) in February 2014.

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.)*