

Bupa Care Services NZ Limited - The Booms Home & Hospital

Current Status: 17 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

Bupa - The Booms provides rest home, hospital and dementia care for up to 69 residents. On the day of audit there were 22 rest home residents, 19 hospital residents and 22 residents in the dementia unit. The Booms has an experienced aged care facility manager (registered nurse (RN)), supported by an operations manager and clinical manager (RN). Bupa provides a comprehensive orientation and training/support programme for their staff. The service is sufficiently staffed to provide safe delivery of care. Residents and relatives interviewed spoke positively about the care and support provided. There were no shortfalls identified in this audit.

The service is commended for achieving four continued improvement (CI) ratings around their focus on the use of evidenced-based research to reduce resident falls, reduce medicine errors, enhance the environment for residents in the dementia unit, its collaboration with Age Concern to reduce falls in the community, its focus improving staff health and its focus on minimising the exposure of infections for consumers, service providers and visitors.

Audit Summary as at 17 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

Indicator	Description	Definition
	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 17 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.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational Management as at 17 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 17 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 17 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 17 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 17 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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Audit Results as at 17 September 2014

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). Information about the Code and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented according to the Code. Complaints and concerns are managed and documented. Residents and relatives spoke very positively about care provided by staff. There is a Maori Health Plan and implemented policy in place to support practice. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Organisational Management

The facility is governed by the Bupa Group. Bupa has a business plan in place and the facility operates a quality plan, which includes goals for the calendar year. The quality and risk management system is overseen and coordinated by Bupa head office staff. Key components of the quality management system are in place. An annual resident/relative satisfaction survey is completed and there are regular resident/relative and staff meetings where quality and risk performance is reported. The performance in the facility is benchmarked against other comparable Bupa rest home, dementia and hospital units. The service has implemented a number of quality improvements aimed at maximising the health of residents. There are human resources policies in place to guide recruitment of new employees and their selection, orientation and ongoing staff training and development. There is an in-service training programme covering relevant aspects of care and support and external training which is well attended by staff. The organisational staffing policy aligns with contractual requirements and includes skill mix. Staffing levels are monitored closely with staff input into rostering.

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/whānau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Changes to health status and interventions required are updated on the care plans to reflect the residents current health status. Resident files include notes by the GP and allied health professionals. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed 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 meets 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 hours a day, seven days a week.

Safe and Appropriate Environment

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area 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 ensembles. 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 has been 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 central heating and the temperature is comfortable and constant. Electrical equipment is checked annually. All medical equipment and all hoists are serviced and calibrated annually. Hot water temperatures are monitored.

Restraint Minimisation and Safe Practice

Staff aim to minimise restraint usage. Restraint usage has remained low since 2010. There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager, who is a registered nurse, oversees restraint usage within the facility. The service currently has one resident in the hospital using a restraint, which is a bedrail at the family's request, and there are two hospital level residents voluntarily using enablers, one of whom uses a lap belt and bedrails and the other who uses bedrails. A register for restraints and enablers is maintained and there is evidence of three-monthly evaluation. Review of restraint use across the group is reviewed at regional restraint approval groups and at the facility restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

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 control programme has been reviewed annually. The infection prevention and control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection prevention and control co-ordinator is supported by the Bupa quality team. Infection prevention and control training is provided at least annually for staff. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection prevention and control co-ordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection prevention and control events. 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 - The Booms Home & Hospital
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	The Booms Home & Hospital
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: 17 September 2014 End date: 18 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:	63

Audit Team

Lead Auditor	XXXXXXX	Hours on site	12	Hours off site	8
Other Auditors	XXXXXXX	Total hours on site	12	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	3

Sample Totals

Total audit hours on site	24	Total audit hours off site	19	Total audit hours	43
Number of residents interviewed	5	Number of staff interviewed	11	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	9	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	64	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXX, 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 Monday, 20 October 2014

Executive Summary of Audit

General Overview

Bupa - The Booms provides rest home, hospital and dementia care for up to 69 residents. On the day of audit there were 22 rest home residents, 19 hospital residents and 22 residents in the dementia unit. The Booms has an experienced aged care facility manager (registered nurse (RN)) supported by an operations manager and clinical Manager (RN). Bupa provides a comprehensive orientation and training/support programme for their staff. The service is sufficiently staffed to provide safe delivery of care. Residents and relatives interviewed spoke positively about the care and support provided. There were no shortfalls identified in this audit.

The service is commended for achieving four continued improvement (CI) ratings around their focus on the use of evidenced-based research to reduce resident falls, reduce medicine errors, enhance the environment for residents in the dementia unit, its collaboration with Age Concern to reduce falls in the community, its focus improving staff health, and its focus on minimising the exposure of infections for consumers, service providers and visitors.

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). Information about the Code and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented according to the Code. Complaints and concerns are managed and documented. Residents and relatives spoke very positively about care provided by staff. There is a Maori Health Plan and implemented policy in place to support practice. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Outcome 1.2: Organisational Management

The facility is governed by the Bupa Group. Bupa has a business plan in place and the facility operates a quality plan, which includes goals for the calendar year. The quality and risk management system is overseen and coordinated by Bupa head office staff. Key components of the quality management system are in place. An annual resident/relative satisfaction survey is completed and there are regular resident/relative and staff meetings where quality and risk performance is reported. The performance in the facility is benchmarked against other comparable Bupa rest home, dementia and hospital units. The service has implemented a number of quality improvements aimed at maximising the health of residents. There are human resources policies in place to guide recruitment of new employees and their selection, orientation and ongoing staff training and development. There is an in-service training programme covering relevant aspects of care and support and external training which is well attended by staff. The organisational staffing policy aligns with contractual requirements and includes skill mix. Staffing levels are monitored closely with staff input into rostering.

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. Changes to health status and interventions required are updated on the care plans to reflect the residents current health status. Resident files include notes by the GP and allied health professionals. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed 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 meets 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 hours a day, seven days a week.

Outcome 1.4: Safe and Appropriate Environment

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area 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 ensembles. 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 has been 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 central heating and the temperature is comfortable and constant. Electrical equipment is checked annually. All medical equipment and all hoists are serviced and calibrated annually. Hot water temperatures are monitored.

Outcome 2: Restraint Minimisation and Safe Practice

Staff aim to minimise restraint usage. Restraint usage has remained low since 2010. There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager, who is a registered nurse, oversees restraint usage within the facility. The service currently has one resident in the hospital using a restraint, which is a bedrail at the family's request, and there are two hospital level residents voluntarily using enablers, one of whom uses a lap belt and bedrails and the other who uses bedrails. A register for restraints and enablers is maintained and there is evidence of three-monthly evaluation. Review of restraint use across the group is reviewed at regional restraint approval groups and at the facility restraint meetings. 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 control programme has been reviewed annually. The infection prevention and control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection prevention and control co-ordinator is supported by the Bupa quality team. Infection prevention and control training is provided at least annually for staff. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection prevention and control co-ordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection prevention and control events. 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	1	49	0	0	0	0	0
Criteria	4	97	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	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	CI	

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>The service is using evidenced-based practice to improve falls management and medicine related errors for all residents and is engaging in falls prevention activities in the local community in collaboration with Age Concern. There is a focus on improving the environment for residents in the dementia unit and there is a focus on improving staff health.</p> <p>Total falls by residents over all areas of the facility have reduced from 244 falls in 2013 down to 85 falls this year to date (ie, the first 6 months of 2014). This is a possible annualised projected improvement of 30% over 2013 figures. Medicine related incidents over all areas have reduced from 105 errors in 2013 down to only 8 errors year to date (ie, first 6 months). This is a possible annualised projected improvement of 85%. These changes are significant and have been attributed to an increased focus on falls and medicine related errors as part of the 2014 Quality Plan objectives, the change in clinical manager and changes in clinical practice. All residents are assessed by a physiotherapist. All residents who fall are now seen by the general practitioner or nurse practitioner either the day of the fall or the next working day. All residents are now seen by the general practitioner or nurse practitioner at least monthly. Falls and medicine errors are discussed at the weekly registered nurse meeting and corrective actions are taken as appropriate. The Booms now participates in the Waikato DHB Vitamin D programme, as research is showing that Vitamin D supplements are conducive to minimising falls and minimising harm from the fall. More sensor mats and landing strips have been purchased so that staff are alerted to residents who are at risk of falling as soon as they get out of bed. The use of low-low hydraulic beds and mattresses being placed by beds to prevent injury are also being used. The use of restraint and enablers has been consistently low since the previous certification audit in September 2010 and has not influenced the results.</p> <p>Other quality initiatives have been implemented which focus on improving and enhancing the environment in the dementia unit. This focus on the environment is consistent with evidenced-based research showing that residents with dementia do benefit from a stimulating environment which includes safe sensory and visual stimulation. Staff have been asked to contribute their personal best projects toward enhancing the dementia unit to make it a more interactive environment. The unit now has a number of specially decorated areas to prompt memories (eg; a shop, a nursery area, a kitchen area, a photograph room and an area for hats) and to enhance feelings of wellbeing. Staff believe that the environment and atmosphere within the unit has been transformed and it is certainly very visually stimulating.</p> <p>There has been an organisational wide focus on staff health and wellbeing with the introduction of the 'Bfit' programme, which is consistent with evidence-based research about a healthy workforce. This programme has included education and support for staff around personal exercise, correct resident lifting and handling, and supporting them to feel more valued. Management believe that</p>

Code	Name	Description	Attainment	Finding
				<p>staff are more positive and happier and are keeping themselves safer through better manual handling techniques. Management believe that this is resulting in more positive staff interactions with residents and families.</p> <p>The Booms have also implemented a falls group for the community in collaboration with Age Concern and in doing so are demonstrating social responsibility consistent with Bupa's organisational values.</p>
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.	CI	<p>There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The Booms is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of meetings and discussion with the management team. There continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established at The Booms for indicators above the benchmark. Clinical improvements include being part of the WDHB Vitamin D programme. More sensor mats and landing strips have been purchased so staff are alerted to residents who are at risk of falling as soon as they get out of bed. There has been a reduction in the monthly KPIs since last year. Better GP/NP service so problems can be identified earlier and issues prevented. The management team advised that the drive this year has been for improving staff morale and getting the staff to contribute back to and be part of the home and part of the resident's life. Staff have been asked to contribute their personal best projects toward enhancing the dementia unit to make it an interactive environment. Working with the maintenance man the unit now has an old shop, an old bar, a kitchen for use, a photograph room and a hat dress up area – all part of staff ideas. The environment and atmosphere within the unit has been transformed. The second drive to improve has been supporting staff health and wellbeing with the Bfit programme, education and support around lifting and handling and supporting them also in education and in feeling valued. Advised that staff attitude is very positive, are keeping themselves safe and are happier at work which reflects directly back to positive interactions with their residents.</p>
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	CI	<p>The homes GP reviews the residents monthly or earlier if required and visits twice weekly. The independent nurse practitioner (NP) for residential elder care services (interviewed) has a client base including residents at The Booms. She liaises closely with the contracted GP completing twice weekly visits and resident reviews. The nurse practitioner is able to complete reviews, assess and examine residents of RN concern, order tests, send off referrals (nursing specialists, mental health services) and prescribe as per the nurse practitioner</p>

Code	Name	Description	Attainment	Finding
				<p>standing orders. The NP has direct on-line access to the resident's medicals notes and history (as demonstrated). There is improved continuity of care with regular monthly review of each resident, twice weekly visits and on-line access to records. The NP is available from 8am to 8pm for visits and can telephone triage after hours, advising and supporting the RN team. There is locum GP over provided as required. The NP is positive about the care her residents receive at the facility, the communication and RN clinical assessments. The families are invited to attend GP visits and reviews. The continuity of clinical and medical care has reduced the number of hospital admissions.</p> <p>The service contracts a qualified physiotherapist twice a week for a total of four hours. The Physiotherapist completes initial Physio assessments, equipment assessments and exercise plans for residents. The Physio predominantly works within the rest home/hospital wing and referrals to assess residents in other areas comes through the RN, NP or GP. The Physio also has provided training to staff on moving and handling with a session otherwise the manager completes this at least every 2 months.</p>
HDS(IPC)S.2008	Criterion 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.	CI	<p>Infection control initiatives have seen the introduction of a review process and reduction of total number of catheters used; as well as focus on reduction of urinary tract infections(UTI)s by regular promotion of fluid rounds and the type of fluids given, education provided through toolbox talks by IFC Committee members and RNs and feeding back information on progress to staff monthly. The service has experienced a scabies outbreak (February 2013). Relevant personnel were notified. There is a separate report outlining the outbreak management and line listing of all residents affected. The GP examined and monitored residents affected. All residents and staff were treated. Residents received education around scabies and this is evidenced in the resident meeting minutes. An improvement was identified to ensure the facility holds at least a week's supply of treatment. This has been implemented. The manager has maintained a treatment record including fleas, worms and vet checks for each animal to ensure all home animals are in good health and do not cause any harm to the residents.</p>

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

The Code of Health and Disability Services Consumers' Rights (the Code) is clearly visible throughout the facility and is described in a range of documentation. Staff can describe how the Code is implemented in their everyday delivery of care to residents. The service provides families and residents with information on the Code on entry to the service. Staff receive training about the Code at induction and through on going in-service training (last training was provided on 4 March 2014 and 12 staff attended). Staff also complete competency questionnaires on the Code. An internal audit was last conducted in May 2014 which showed 100 percent compliance.

All care staff interviewed demonstrated an understanding of the key principles of the Code (ie, the facility manager, the clinical manager, the unit coordinator (hospital and rest home), two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit)).

Interviews with five of five residents (ie, two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident) identified they are aware of the Code.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

D6.1, D6.2 and D16.1b.iii: The information pack provided to residents on entry includes a copy of the Code, information on how to make a complaint, and information on the Nationwide Health and Disability Advocacy Service. The service is able to provide this information in different languages and/or in larger print if requested. If necessary, staff will read and explain this information to residents. On entry to the service, the facility manager or the clinical manager will discuss the information pack with the resident and the family/whānau. This includes the code, complaints and advocacy information. The foyer includes information on advocacy and advocacy pamphlets are available around the facility. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Interviews with five of five residents (ie, two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident) identified they are aware of their rights and aware that they can talk to the managers at any time if they have any concerns.

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:

Staff show respect for privacy and personal space (observed during the two day onsite audit). Resident files are held in the locked nurses' offices. All care staff interviewed demonstrated an understanding of privacy (ie, the facility manager, the clinical manager, the unit coordinator (hospital and rest home, two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit).

Residents and family members interviewed confirm that staff promote resident independence wherever possible and that resident choice is encouraged (eg: what to wear, when to get up for the day, where to eat and meal alternatives) and that staff are obliging around choice and treat residents with respect (confirmed in interviews with five of five residents (ie, two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident). The August 2013 resident satisfaction survey identified no dissatisfaction regarding privacy and 98% of respondents expressed satisfaction with the amount of choice they were able to make. Care plans reviewed identified specific individual likes and dislikes.

Staff practice is guided by the Code of Conduct and a range of policies. Bupa have a neglect and abuse policy which includes definitions and examples of abuse so that staff are clear on Bupa's expectations. Abuse and neglect training was last delivered in February and repeated in April 2014 and a total of 29 staff attended one of the two sessions).

D3: Resident information provided on admission outlines Bupa's vision and values.

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Person centred care/individuality and independence training is provided to staff annually.

D4.1a Cultural and religious beliefs of residents are considered through the admission and assessment process.

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

E 4.1a: Residents in the dementia service are encouraged to maintain their independence where possible (confirmed in discussion with the relative of one resident and two of two caregivers on duty in the dementia unit).

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:

Residents who identify as Maori have their cultural values respected by staff. At the time of audit two residents identified as Maori. Several staff identified as Maori. Staff receive on-going education on cultural awareness including respect for tikanga (last education session provided 26 March 2014 which was a training package that was completed by 12 staff). All care staff interviewed were aware of these residents and tikanga (ie, the facility manager, the clinical manager, the unit coordinator (hospital and rest home, two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit).

A3.1: Residents who identify themselves as Maori are provided with services that acknowledge their individual values and beliefs.

A3.2: There is a Maori health plan includes a description of how they will achieve these requirements.

D20.1i: The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa's facilities. The ADHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. The Booms has an attachment to the policy that relates specifically to their area. Local Iwi and contact details of tangata whenua are identified.

Social events and occasions are celebrated at the Booms and this could be described by staff. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process.

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member's stay/care.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An initial care planning meeting occurs on admission and in the weeks shortly thereafter where beliefs or values are discussed and incorporated into the resident's plan of care. Six monthly multi-disciplinary team meetings are held to review care and to assess if staff are appropriately meeting the needs of each resident. Family are invited to participate in this process as appropriate. Family assist residents to complete their 'map of life' which provides staff with a broad understanding of the resident.

Residents and family members interviewed confirm that the values and beliefs of residents are considered and staff respect cultural values (confirmed in interviews with five of five residents (ie, two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident).

D3.1g: The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment, planning process and interviews with residents confirmed that cultural values and beliefs were considered and discussed during review of the care plan.

D4.1c: Eight of eight resident's files reviewed included information on the resident's social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The Bupa Code of Conduct for staff is included in each employee pack of information given when they commence employment. Job descriptions identify responsibilities for each position. Each staff member is contractually obliged under employment law to respect the Bupa Code of Conduct and this is enforced through human resource management practices. There is policy to guide staff practice which covers gifts, gratitude's and benefits and delegations of authority. Registered nurses meet (two monthly) and this meeting includes discussions on staff performance including staff respect for professional boundaries. Bupa management provide guidelines and mentoring for specific situations.

All care staff interviewed were aware of professional boundaries (ie, the facility manager, the clinical manager, the unit coordinator (hospital and rest home), two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit). Staff are aware of the actions they should take in the event that they believe a staff member is not maintaining a professional approach to practice.

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: CI

Evidence:

Bupa provides a quarterly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company (described by RNs at the Booms). The Bupa geriatrician provides newsletters to GPs.

Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Performance at the Booms is currently benchmarked in three areas (rest home, dementia and hospital) against other NZ Bupa facilities. A quality improvement programme is implemented that includes performance monitoring. Graphs and data are provided to management and displayed for staff on the staff noticeboard in the staff room. Corrective actions are completed when trends are evident or areas are identified above the benchmark. Corrective action plans have been established and evaluated for effectiveness.

Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia (e.g. mortality and pressure incidence rates and staff accident and injury rates).

A2.2: Services are provided at the Booms that adhere to the health & disability services standards. There is an established quality improvement programme that includes performance monitoring.

D1.3: All approved service standards are adhered to.

Bupa have a human resources learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.

There is a dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan (sighted with quality meeting minutes). Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation. The service has introduced leadership development of qualified staff, education from human resources, attendance at external education, a qualified nurse's education day and education sessions at monthly meetings.

D17.7c There are implemented competencies for caregivers and registered nurses. Competencies are completed for key nursing skills at the Booms including (but not limited to); a) moving & handling, b) wound care, c) assessment tools and d) medicines management. Registered nurses have access to external training.

The Booms' annual quality plan for 2014 includes two consumer related goals which are to reduce consumer falls by 10 percent across all areas and to reduce consumer related medicine related incidents by 70 percent for the year. Results to date for the 2014 calendar year show that there has been a significant reduction in falls across the rest home, dementia unit, and hospital area. Falls have reduced in the rest home from 58 falls in 2013 down to 16 year to date (ie, first 6 months), which is a possible annualised projected improvement of approximately 45 percent. Falls have reduced in the dementia unit from 103 falls in 2013 down to 33 year to date (ie, first 6 months), which is a possible annualised projected improvement of approximately 36 percent. Falls have reduced in the hospital unit from 83 falls in 2013 down to 36 year to date (ie, first 6 months), which is a possible annualised projected improvement of approximately 13 percent. Total falls over all areas have reduced from 244 in 2013 down to 85 year to date (ie, first 6 months), which is a possible annualised projected improvement of 30 percent. Medicine related incidents over all areas have reduced from 105 in 2013 down to 8 year to date (ie, first 6 months), which is a possible annualised projected improvement of 85 percent. The significant changes have been the increased focus on falls and medicine related errors and the change in clinical manager. All residents who fall are now seen by the general practitioner or nurse practitioner either the day of the fall or the next working day. All residents are now seen by the general practitioner or nurse practitioner at least monthly. Falls and medicine errors are discussed at the

weekly registered nurse meeting. The Booms now participates in the Waikato DHB Vitamin D programme which evidenced-based research is showing is conducive to minimising falls. More sensor mats and landing strips have been purchased so that staff are alerted to residents who are at risk of falling as soon as they get out of bed. The use of low-low hydraulic beds and mattresses being placed by beds to prevent injury are being used. The use of restraint and enablers has been consistently low since the previous certification audit in September 2010.

Other quality initiatives have focused on improving and enhancing the environment in the dementia unit which is consistent with research showing that residents with dementia benefit from a stimulating environment which includes sensory and visual stimulation. Staff have been asked to contribute their personal best projects toward enhancing the dementia unit to make it a more interactive environment. The unit now has a number of specially decorated areas to prompt memories (eg, a shop, a nursery area, a kitchen area, a photograph room and an area for hats) and to enhance feelings of wellbeing. Staff believe that the environment and atmosphere within the unit has been transformed and it is certainly very visually stimulating.

There has been an organisational wide focus on staff health and wellbeing with the introduction of the 'Bfit' programme which is consistent with evidence-based research about a healthy workforce. This programme has included education and support for staff around personal exercise, correct resident lifting and handling, and supporting them to feel more valued. Management believe that staff are more positive and happier and are keeping themselves safer through better manual handling techniques. Management believe that this is resulting in more positive staff interactions with residents and families.

The Booms have also implemented a falls group for the community in collaboration with Age Concern and in doing so are demonstrating social responsibility consistent with Bupa's organisational values.

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: CI

Evidence:

The Booms has an annual quality plan in which it identifies goals for the calendar year. The Booms' annual quality plan for 2014 includes two consumer related goals which are to reduce consumer falls by 10% across all areas and to reduce consumer related medicine related incidents by 70% for the year. Results to date for the 2014 calendar year show that there has been a significant reduction in falls across the rest home, dementia unit, and hospital area. Falls have reduced in the rest home from 58 falls in 2013 down to 16 year to date (ie; first 6 months), which is a possible annualised projected improvement of approximately 45%. Falls have reduced in the dementia unit from 103 falls in 2013 down to 33 year to date (ie; first 6 months), which is a possible annualised projected improvement of approximately 36%. Falls have reduced in the hospital unit from 83 falls in 2013 down to 36 year to date (ie; first 6 months), which is a possible annualised projected improvement of approximately 13%. Total falls over all areas have reduced from 244 in 2013 down to 85 year to date (ie; first 6 months), which is a possible annualised projected improvement of 30%. Medicine related incidents over all areas have reduced from 105 in 2013 down to 8 year to date (ie; first 6 months), which is a possible annualised projected improvement of 85%. The significant changes have been the increased focus on falls and medicine related errors and the change in clinical manager. All residents are assessed by a physiotherapist. All residents who fall are now seen by the general practitioner or nurse practitioner either the day of the fall or the next working day. All residents are now seen by the general practitioner or nurse practitioner at least monthly. Falls and medicine errors are discussed at the weekly registered nurse meeting. The Booms now participates in the Waikato DHB Vitamin D programme which evidenced-based research is showing is conducive to minimising falls. More sensor mats and landing strips have been purchased so that staff are alerted to residents who are at risk of falling as soon as they get out of bed. The use of low-low hydraulic beds and mattresses being placed by beds to prevent injury are being used. The use of restraint and enablers has been consistently low since the previous certification audit in September 2010.

Other quality initiatives have focused on improving and enhancing the environment in the dementia unit which is consistent with research showing that residents with dementia benefit from a stimulating environment which includes sensory and visual stimulation. Staff have been asked to contribute their personal best projects toward enhancing the dementia unit to make it a more interactive environment. The unit now has a number of specially decorated areas to prompt memories (eg, a shop, a nursery area, a kitchen area, a photograph room and an area for hats) and to enhance feelings of wellbeing. Staff believe that the environment and atmosphere within the unit has been transformed and it is certainly very visually stimulating.

There has been an organisational wide focus on staff health and wellbeing with the introduction of the 'Bfit' programme which is consistent with evidence-based research about a healthy workforce. This programme has included education and support for staff around personal exercise, correct resident lifting and handling, and supporting them to feel more valued. Management believe that staff are more positive and happier and are keeping themselves safer through better manual handling techniques. Management believe that this is resulting in more positive staff interactions with residents and families.

The Booms have also implemented a falls group for the community in collaboration with Age Concern and in doing so are demonstrating social responsibility consistent with Bupa's organisational values.

Finding:

The service is using evidenced-based practice to improve falls management and medicine related errors for all residents and is engaging in falls prevention activities in the local community in collaboration with Age Concern. There is a focus on improving the environment for residents in the dementia unit and there is a focus on improving staff health.

Total falls by residents over all areas of the facility have reduced from 244 falls in 2013 down to 85 falls this year to date (ie, the first 6 months of 2014). This is a possible annualised projected improvement of 30% over 2013 figures. Medicine related incidents over all areas have reduced from 105 errors in 2013 down to only 8 errors year to date (ie, first 6 months). This is a possible annualised projected improvement of 85%. These changes are significant and have been attributed to an increased focus on falls and medicine related errors as part of the 2014 Quality Plan objectives, the change in clinical manager and changes in clinical practice. All residents are assessed by a physiotherapist. All residents who fall are now seen by the general practitioner or nurse practitioner either the day of the fall or the next working day. All residents are now seen by the general practitioner or nurse practitioner at least monthly. Falls and medicine errors are discussed at the weekly registered nurse meeting and corrective actions are taken as appropriate. The Booms now participates in the Waikato DHB Vitamin D programme, as research is showing that Vitamin D supplements are conducive to minimising falls and minimising harm from the fall. More sensor mats and landing strips have been purchased so that staff are alerted to residents who are at risk of falling as soon as they get out of bed. The use of low-low hydraulic beds and mattresses being placed by beds to prevent injury are also being used. The use of restraint and enablers has been consistently low since the previous certification audit in September 2010 and has not influenced the results.

Other quality initiatives have been implemented which focus on improving and enhancing the environment in the dementia unit. This focus on the environment is consistent with evidenced-based research showing that residents with dementia do benefit from a stimulating environment which includes safe sensory and visual stimulation. Staff have been asked to contribute their personal best projects toward enhancing the dementia unit to make it a more interactive environment. The unit now has a number of specially decorated areas to prompt memories (eg; a shop, a nursery area, a kitchen area, a photograph room and an area for hats) and to enhance feelings of wellbeing. Staff believe that the environment and atmosphere within the unit has been transformed and it is certainly very visually stimulating.

There has been an organisational wide focus on staff health and wellbeing with the introduction of the 'Bfit' programme, which is consistent with evidence-based research about a healthy workforce. This programme has included education and support for staff around personal exercise, correct resident lifting and handling, and supporting them to feel more valued. Management believe that staff are more positive and happier and are keeping themselves safer through better manual handling techniques. Management believe that this is resulting in more positive staff interactions with residents and families.

The Booms have also implemented a falls group for the community in collaboration with Age Concern and in doing so are demonstrating social responsibility consistent with Bupa's organisational values.

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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

Accident/incidents, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy is in place to guide staff on the process to ensure full and frank open disclosure occurs. The clinical manager and two of two registered nurses interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms include reference as to whether family/whanau have been informed (or not) of the accident/incident. A total of 39 accident/incident forms were reviewed for August 2014. Staff recorded on the accident/incident form if family were contacted and which family member was contacted. Relatives were contacted in 37 of 39 events. The two instances where relatives were not informed were because in one instance the relative was present at the time of the incident and the other relative had left instructions only to be contacted in the event of a major incident or accident and the event was minor in nature. Management monitor performance as part of the internal auditing system. The latest internal audit was completed in April 2014 which resulted in 100% compliance. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur and their preferences are documented in the resident files.

D16.4b: Four of four relatives interviewed (two rest home, one dementia and one hospital) stated that they are always informed by staff when their family members health status changes.

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

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

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

A13.1; A13.2; A14.1; D16.1b.ii, D 20: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

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

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

Attainment and Risk: FA

Evidence:

The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents including outings on seven of seven resident files sampled (two rest home, three hospital, two dementia care) Resuscitation treatment plans and advance directives are appropriately signed in the seven of seven files reviewed.

Discussions with five caregivers (three rest home/hospital and two 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 are 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. There are copies of EPOA and GP letter of mental capacity held in the files of the two dementia care residents records sighted.

D13.1 there were six admission agreements and one short stay admission agreements sighted and all had been signed.

D3.1.d Discussion with four families (one dementia, one 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:

Staff practice is guided by the advocacy policy. Residents are provided with a copy of the Code and advocacy pamphlets on entry. The facility manager, the clinical manager, the unit coordinator and two of two registered nurses are aware of advocacy and support options for residents. Residents and family members interviewed confirm that they are aware of their right to access advocacy support (confirmed in interviews with five of five residents (ie; two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident). Chaplains visit at least fortnightly and meet individually with residents. Management believe that these chaplains would act as advocates for residents if there was a need identified by either the resident or the chaplain. In addition an independent advocate also visits the facility on a random basis.

Staff receive education on the Code and the provision of advocacy services (last education session held 4 March 2014, which was attended by 12 staff).

D4.1d: The service provides opportunities for the family/EPOA to be involved in decision-making.

D4.1e: Eight of eight resident files reviewed included information on resident's family/whanau and chosen social networks

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents are encouraged to maintain their connections with their family and the wider community. Visitors were observed coming and going throughout the duration of the onsite audit and the managers maintain regular contact with families. There is a family/whanau participation and contact policy in place to guide staff. The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the Census.

D3.1.e: Residents and family members interviewed confirm that staff help them to maintain their links to family and to access the community as much as possible (confirmed in interviews with five of five residents (ie; two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident)).

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Staff receive training on complaint management (education last provided 29 April 2014 and was attended by 16 staff).

D6.2 & E4.1biii: Residents and their families are provided with information on the right to complain on entry to the facility. The number of complaints received each month is reported monthly to the regional manager and Bupa Care Services. Bupa defines a complaint as any dissatisfaction raised about the services it provides to its customers which is a broader definition of consumer complaints than that required by the Code (ie; complaints recorded include consumer complaints and complaints by people who are not legally entitled to give consent on behalf of a resident and others (eg; staff, contractors)).

In 2014 the service has received a total of six complaints of which two matters raised were determined to be justified following investigation. All complaints are followed up with corrective actions initiated.

There is currently one HDC complaint in the process of being investigated.

D13.3h: The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register and documentation is maintained for each complaint.

Residents and family members interviewed confirm that they are aware of the complaints process (confirmed in interviews with five of five residents (ie, two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident)).

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:

The Booms Home and Hospital owned and operated by Bupa Care Services NZ (Bupa), which has a head office in Auckland. The Booms provides rest home, dementia and hospital level care for up to 69 residents. On the day of audit there were 22 rest home residents including one resident aged under 64 years of age (with an additional two rest home residents in hospital), 22 dementia residents and 19 hospital residents. There were no residents receiving services under the medical component of their certification.

Bupa have a three year strategic plan in place covering 2012 to 2015 (sighted), which is available on the Intranet. The strategic plan identifies the overall objectives of the business. There is an Bupa business plan and risk management plan in place. There is an annual quality plan in place for the Booms which includes specific quality goals. The specific quality goals for the Booms for 2014 are as follows:

1. To reduce falls by 10% in all areas and to reduce medication incidents by 70% for the year (progress year to date shows significant improvements)
2. To have bi-monthly moving and handling training sessions with all the staff (this is on target and staff injuries have reduced)
3. To promote the Booms Home and Hospital in the community and improve occupancy to 96%
4. To enhance staff morale.

Quarterly quality reports on progress towards meeting the quality goals identified are completed at the Booms and forwarded to the Bupa Quality and Risk team by the facility manager (meeting minutes reviewed included discussing on-going progress to meeting their goals).

The facility manager provides a documented weekly management report to the Bupa operations manager. The operations manager visits the facility on average twice a month and completes a report to the general manager. The Booms is part of the Midlands Bupa region, which currently includes 14 facilities. The managers in the region teleconference monthly and regional meetings are held at least three monthly. A national conference forum is held every February and October for all Bupa managers.

Bupa has a Clinical Governance group for all sites. The committee meets two monthly. The committee reviews the past and looking forward. Specific issues identified in the Health and Disability Commissioner's reports (learning's from other provider complaints) are also tabled at this forum. Feedback is provided to managers at forums and also to staff through newsletters (sighted at the Booms). Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly. Feedback is provided to each facility (sighted).

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia (eg, mortality and pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced in January 2010 (NZ benchmarking information was sighted).

The Booms has an experienced facility manager (who is a practising registered nurse). She has been in the role for the last seven years and was previously employed as the clinical manager at the facility for two years prior to her appointment. The facility manager is supported by a clinical manager (who is a practising registered nurse who has been in the role since 5 November 2013. She was previously employed at the facility as a registered nurse for three years prior to her appointment. There are job descriptions for both positions that include responsibilities and accountabilities (sighted). Bupa provides a comprehensive orientation and training/support programme for their managers. Facility and clinical managers attend annual organisational forums and regional forums six monthly.

D17.3di the facility manager and clinical manager have both maintained at least eight hours annually of professional development activities related to managing a hospital (confirmed in discussion with the facility manager and in review of the clinical manager's file). Both the manager and the clinical manager has completed NZQA standards in dementia care.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

During a temporary absence, the clinical manager covers the facility manager's role. The service is supported by the Bupa Operations Manager. The clinical manager takes overall responsibility for clinical care and reports to the facility manager. She is assisted by a unit coordinator and senior caregivers

Bupa has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to residents that require hospital (medical), and rest home care. All residents have a general practitioner. The majority of residents are cared for by one medical centre. A general practitioner from this practice visits the facility Tuesdays and Fridays and a nurse practitioner from that practice visits the home on Mondays and Thursdays. General practitioners are on call if needed. A physiotherapist visits the facility for four hours a week. The physiotherapist reviews all new admissions and any other resident where there is an identified need. She develops mobilisation plans for all residents which are kept in their clinical records. The physiotherapist assists the facility manager who is a qualified manual handling instructor to ensure safe manual handling occurs throughout the facility.

The facility consults with the Bupa dementia leadership group, the dietitian, and mental health for older people and other specialist teams as needed.

D19.1a; Bupa recognises its safety obligations and has implemented operational management strategies and programmes to minimise unwanted events and to enhance quality. There are a suite of policies, related procedures and forms in place to guide staff practice, enhance quality and to minimise the risk of unwanted events occurring.

E3.3a: The Dementia unit accommodates more than 20 residents and on the day of audit was providing care for 22 residents. The facility has approval from the Ministry of Health to extend the dementia unit to 27 beds if necessary (approval letter from Ministry of Health dated 21 November 2011 sighted).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Booms Home and Hospital uses the Bupa quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Bupa policies and procedures have been implemented throughout the year. All facilities have a master copy of all policies, procedures and forms and documents are available electronically on the intranet. These documents have been developed in line with current accepted best and/or evidenced-based practice. 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. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the Quality and Risk team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule. Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation. The release is notified by email to all facility and clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the monthly quality meeting at The Booms. The facility manager reports weekly each Friday to the operations manager (reports sighted) and quality indicator reports are sent to the Bupa quality management coordinator who provides a coordinated process between service level and organisation.

There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the facility. All data is linked to the quality and risk management system including complaints, infections, restraint management and health and safety. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include key performance data.

Corrective action plans are implemented when quality improvements are identified and responsibilities are identified. The service has implemented a number of corrective actions following the results of internal audits (sighted). Corrective action forms are also established for other quality initiatives identified by staff throughout the year and where identified through the internal audit programme. Corrective action plans are monitored within the facility by management and the operations manager is advised.

D19.3: There is a health and safety and risk management programme in place. Health and safety education was last provided to 16 staff on 29 April 2014. There is a hazard identification, assessment and management policy in place to guide practice and a hazard register is in place at the facility (sighted). Bupa also has a health and safety coordinator who monitors staff accidents and incidents nationally. The health and safety systems are included in the internal audit programme (last audit of health and safety was conducted 8 August 2014 which showed 97% compliance and two corrective actions were identified and corrected).The hazard management system was internally audited on 15 April 2014 and two corrective actions were identified and corrected.

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

Staff are familiar with the quality and risk management system (confirmed in interviews with the facility manager, the clinical manager, the unit coordinator (hospital and rest home), two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit) the cook, the activities coordinator, the laundry person and the cleaner).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: CI

Evidence:

Key components of the quality management system link to the monthly quality meeting at The Booms. The facility manager reports weekly each Friday to the operations manager (reports sighted) and quality indicator reports are sent to the Bupa quality management coordinator who provides a coordinated process between service level and organisation.

There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the facility. All data is linked to the quality and risk management system including complaints, infections, restraint management and health and safety. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include key performance data.

Finding:

There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The Booms is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of meetings and discussion with the management team. There continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established at The Booms for indicators above the benchmark. Clinical improvements include being part of the WDHV Vitamin D programme. More sensor mats and landing strips have been purchased so staff are alerted to residents who are at risk of falling as soon as they get out of bed. There has been a reduction in the monthly KPIs since last year. Better GP/NP service so problems can be identified earlier and issues prevented. The management team advised that the drive this year has been for improving staff morale and getting the staff to contribute back to and be part of the home and part of the resident's life. Staff have been asked to contribute their personal best projects toward enhancing the dementia unit to make it an interactive environment. Working with the maintenance man the unit now has an old shop, an old bar, a kitchen for use, a photograph room and a hat dress up area – all part of staff ideas. The environment and atmosphere within the unit has been transformed. The second drive to improve has been supporting staff health and wellbeing with the Bfit programme, education and support around lifting and handling and supporting them also in education and in feeling valued. Advised that staff attitude is very positive, are keeping themselves safe and are happier at work which reflects directly back to positive interactions with their residents.

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 & D19.3c: The service collects incident and accident data in accordance with policy. Serious incidents and accidents are termed category one events and these types of events are listed in policy. Completed accident and incident forms are written by the staff member involved and forwarded to the clinical manager who will then investigate the incident and record the event in the database. The form is then forwarded to the facility manager for further investigation. She reports the incident to the operations manager. The head office quality and risk team are informed as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going). Accident/Incident forms reviewed for August 2014 (ie, 17 rest home, 16 dementia and 6 hospital) identified clinical follow up by a registered nurse and/or clinical manager and appropriate monitoring (eg, neurological observations). Events are analysed by time of day, category and by resident. The original accident and incident form is filed in the resident's clinical record and logged on an event chart so the clinicians can interpret individual patterns that have occurred over time.

Staff are provided with on-going information about adverse event management and the need for open disclosure (last education session was held on 4 March 2014 which was attended by 12 staff).

The accident and incident reporting system is included in the internal audit programme (last audit was conducted in April 2014 which showed 100% compliance).

D19.3b; The service documents and analyses accidents and incidents, and adverse events and provides feedback to the staff so that corrective actions and quality improvements can be identified and implemented. Individual accident or incident reports are completed for each event with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.

Discussions with the facility manager and clinical manager and evidence sighted confirm they have an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Hard copies of health practitioner annual practising certificates (APCs) are held by the facility manager (APCs were sighted for registered nurses, general practitioners, pharmacists, podiatrists, a physiotherapist and a dietitian).

The service has implemented the Bupa orientation programme that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time (eg, caregivers two weeks, registered nurses four weeks).

Staff interviewed (ie, five of five caregivers, the clinical manager and three of three registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (which included the clinical manager, three registered nurses (one new appointee, one infection control coordinator and one restraint coordinator), five caregivers (who work all shifts and includes a range of newly appointed caregivers to experienced). All staff files included a contract of employment, a copy of their job description, evidence of Police and reference checks, evidence of orientation, evidence of qualifications and training attended and annual appraisals were up-to-date where applicable. All staff working in the dementia unit had specific NZQA qualifications.

Caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills NZQA unit standards. On completion of this orientation, they have effectively attained their Level 2 NZQA first national certificate. From this they are then able and encouraged to continue with Core Competencies Level 3 NZQA unit standards. Level 2 NZQA qualifications had been completed by 28 of 32 caregivers (ie 88%) and of those 28 caregivers, 14 had completed the level 3 NZQA core

competencies with Careerforce (ie, 50%). Dementia training modules have been completed by 24 care givers and all 9 registered nurses which includes the clinical manager and the facility manager.

Bupa has a comprehensive annual education schedule in place. All staff are encouraged to attend at least 10 compulsory education sessions per year. Additional education sessions are held including individual education or small group opportunistic tool box training. The monthly programme is always out at the beginning of the month. At the time of audit 23 caregivers had current first aid certificates. The registered nurses attend a training day provided through Bupa once a year that covers clinical aspects of care. Bupa maintains its own Nursing Council of NZ approved PDRP and takes over the responsibility for auditing their qualified nurses. All nine registered nurses attended the Bupa regional registered nurse training day. All registered nurses have submitted their PDRPs and two portfolios have been accepted.

A competency programme is in place with different requirements according to work type (e.g. registered nurse, caregiver, cleaner). Core competencies are completed annually and a record of completion is maintained (sighted in review of employment records). Staff interviewed were aware of the requirement to complete competency training.

Discussion with staff and management and employment record review confirmed that a comprehensive in-service education programme which includes ongoing competency assurance is in place (confirmed in discussions with the facility manager, the clinical manager, the unit coordinator (hospital and rest home, two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit) and in employment record review of the clinical manager, three registered nurses and five caregivers).

D17.7d: RN competencies include but are not limited to; assessment tools, BSLs/Insulin administration, medicines management including controlled drug administration, wound management, moving & handling, nebuliser use, oxygen administration, restraint management, wound management, and the administration of subcutaneous fluids and the use of syringe drivers for residents receiving palliative care.

E4.5b; There is at least one staff member on duty in the dementia unit at all times and additional staff available in the facility (confirmed in interviews with the facility manager, the clinical manager and five of five caregivers).

E4.5d, e: Staff working in the dementia unit receive a planned orientation and are familiarised with the physical layout including the emergency management system in use (confirmed in discussions with two of two caregivers who were on duty in the dementia unit).

E4.5f, g: All caregivers involved in the provision of care in the dementia unit have appropriate dementia qualifications and new staff have commenced studying within 6 months of appointment. Staff working in the dementia unit are overseen by the clinical manager with assistance from the registered nurses on duty. On occasions a registered nurse is employed to work shifts in the dementia unit. Dementia training modules have been completed by 24 care givers and all 9 registered nurses which includes the clinical manager and the facility manager.

E4.5h Records of qualifications are maintained for all staff (database sighted).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy that aligns with contractual requirements and includes policy on skill mix. Bupa uses the WAS (Wage Analysis Schedule), which is based on the safe indicators for aged care and dementia care to determine the staffing requirements for each facility. The WAS is then used as a guide to determine the roster at facility level taking into account resident acuity and needs. A report is provided fortnightly from head office that includes hours and whether hours are consistent with the WAS indicators. The facility manager and the clinical manager are both registered nurses with current practising certificates. Both typically work weekdays from Monday to Friday and are onsite from 8 am to 5 pm. Both are on call for the facility when not on site and they rotate the call requirements between them. There is always at least one registered nurse on duty for each shift in addition to the facility and clinical manager. Often there are two registered nurses on the morning shift with one working in the hospital area and the other working in the dementia unit. At night, there is one registered nurse covering the whole facility. Typically there are seven caregivers plus the registered nurse, the clinical manager and the facility manager on duty in the morning.

E4.5a: Bupa is aware of the need to provide sufficient staff to meet the residents' needs in the dementia unit. Typically the dementia unit is staffed by two staff members from 7 am to 3pm with another staff member working 5 am to 11am to provide additional cares. There is an additional activities person in the unit from 12 pm to 6 pm each day. There are two carers rostered from 3 pm to 11 pm and another rostered from 5 pm to 9 pm. There is one carer on duty from 11pm to 7am. That carer is assisted by the person who commences duty at 5am. The dementia unit layout is challenging for care staff as it has multiple blind spots for staff to manage. Staff report that they can cope with the layout and spend a large percentage of their day checking where everyone is located.

E4.5b: There is at least one staff member on duty in the dementia unit at all times and additional staff are available in the facility. Two of two caregivers on duty in the dementia unit interviewed stated staffing was good.

E4.5c: A registered nurse is employed to oversee the residents in the dementia unit who is the clinical manager and there is an occupational therapist employed by head office to oversee the activities programme.

The facility is located in Thames with limited access to a pool of temporary employees. Staff are at times called upon to work additional shifts during unexpected staff absences. This can result in staff working long hours on occasions. However staff believe the facility is appropriately staffed (confirmed in discussions with the facility

manager, the clinical manager, the unit coordinator (hospital and rest home), two of two registered nurses, and five of five caregivers who worked across all shifts (three who worked in both the hospital and rest home area and two who worked in the dementia unit)).

Interviews with five of five residents (ie, two rest home and three hospital) and four of four relatives (ie, relatives of two rest home resident, one hospital resident and one dementia unit resident) confirm they believe staffing levels are appropriate to meet the needs of residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked room or secure storage for unused files. All resident records contain the name of resident and the person completing the 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. The records management system is included in the internal audit programme (last audit was conducted 8 April 2014 which showed 99% compliance with corrective actions being identified and resolved).

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered 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. Five residents (two rest home, three hospital) and four relatives (two rest home, one 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 /families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

The facility 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. There is good liaison and communication with the needs assessors, social worker, mental health team, GPs and nurse

practitioner. The services provides respite services at all levels of care.

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. Seven admission agreements sighted had all been signed within the required timeframe.

One short stay/respite care admission agreement sighted is signed on admission.

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 would record the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurred. The facility manager (interviewed) states the service has not declined entry to any residents. 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; D16.3f; 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 The Booms provides rest home, hospital and dementia level of care. There is a registered nurse (RN) based in the rest home/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 seven of seven files sampled (two

rest home - includes one younger person, three hospital and two dementia care). There is a short stay nursing assessment and support plan available for use for short stay/respite care residents. Within three weeks, the long term care plan is developed in seven permanent resident files sampled.

In all seven permanent resident files sampled (two rest home, three hospital and two dementia care) the initial admission assessment, care plan summary and long term care plans are 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 seven permanent files sampled. It was noted in resident files reviewed that the GP reviews the residents monthly or earlier if required and visits twice weekly. The independent nurse practitioner (NP) for residential elder care services (interviewed) has a client base including residents at The Booms. The service contracts a qualified physiotherapist twice a week for a total of four hours.

Five care staff interviewed (two dementia care, three rest home/hospital) could describe a verbal handover 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. Seven files sampled identified integration of allied health and a team approach.

In the seven files sampled 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: CI

Evidence:

It was noted in resident files reviewed that the GP reviews the residents monthly or earlier if required and visits twice weekly. The independent nurse practitioner (NP) for residential elder care services (interviewed) has a client base including residents at The Booms. The service contracts a qualified physiotherapist twice a week for a total of four hours.

In the seven files sampled 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.

Finding:

The homes GP reviews the residents monthly or earlier if required and visits twice weekly. The independent nurse practitioner (NP) for residential elder care services (interviewed) has a client base including residents at The Booms. She liaises closely with the contracted GP completing twice weekly visits and resident reviews. The nurse practitioner is able to complete reviews, assess and examine residents of RN concern, order tests, send off referrals (nursing specialists, mental health services) and prescribe as per the nurse practitioner standing orders. The NP has direct on-line access to the resident's medicals notes and history (as demonstrated). There is improved continuity of care with regular monthly review of each resident, twice weekly visits and on-line access to records. The NP is available from 8am to 8pm for visits and can telephone triage after hours, advising and supporting the RN team. There is locum GP over provided as required. The NP is positive about the care her residents receive at the facility, the communication and RN clinical assessments. The families are invited to attend GP visits and reviews. The continuity of clinical and medical care has reduced the number of hospital admissions.

The service contracts a qualified physiotherapist twice a week for a total of four hours. The Physiotherapist completes initial Physiotherapy assessments, equipment assessments and exercise plans for residents. The Physiotherapist predominantly works within the rest home/hospital wing and referrals to assess residents in other areas come through the RN, NP or GP. The Physiotherapist also has provided training to staff on moving and handling with a session otherwise the manager completes this at least every 2 months.

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:

The Booms 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. A nutritional requirements is completed on admission. Additional risk assessment tools include behaviour, cultural and wound assessments as applicable. The outcomes of risk assessments are reflected in the seven care plans sampled (two rest home, three hospital and two dementia care).

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; Two dementia resident files 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, and 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 demonstrate input from allied health. Residents (three hospital, two rest home) and families (two rest home, one 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 the care planning and care plan evaluation process. There is documented evidence on the care plan and in the family contact form of family involvement in care plan process. The long-term care plan is completed within three weeks in seven of seven residents files sampled.

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. There is a specific needs for dementia care included in the files of residents with dementia. Long term residents' care plans reviewed on the day of the audit (two rest home, three hospital, two dementia care) provide evidence of individualised support.

D16.3k, Short term care plans are in use for short term needs and changes in health status.

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: FA

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, NP or specialist consultation. There is documented evidence written on the family contact record 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. Four relatives interviewed confirm they are notified with any RN resident concerns and any significant events. They state the staff are very approachable if they wish to discuss their relative's health at any time.

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 were provided in March and April 2014 with good attendance. All RNs attended wound management in-service March 2014. 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 and NP involvement in the one chronic wound (failed donor site) for a hospital resident. The wound is linked to the long term care plan. There is a comprehensive wound assessment with on-going evaluations and photos. There are currently no wounds or skin tears in the dementia care unit. There are three skin tears and one minor lesion in the rest home. In the hospital wing there are five skin tears, three minor lesions and the chronic wound. One hospital resident has grade 1 sacral pressure area and another hospital resident was admitted with a sacral and lower leg pressure areas. Pressure area risk assessments are completed and interventions are documented in the residents care plans. There are wound assessments and on-going evaluations for all wounds and skin tears. Short term care plans are in place.

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, lowa pain monitoring tool and neurological observations. Residents diagnosed with dementia and/or challenging behaviours have a dementia specific needs care plan that includes the types of behaviour, triggers and alternative strategies and distractions (including activities) to manage behaviours. Behaviour monitoring charts are commenced for any new or escalating behaviours (sighted). The GP, NP and mental health services are readily available as required.

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:

The activities co-ordinator has been in the role seven years and has the national certificate in the support of the older person and NZQA dementia units. She is predominantly based in the rest home/hospital and implements the integrated programme seven and a half hours a day Monday to Friday. There is a company occupational therapist that oversees the overall programme. The activity team attend the Bupa training days and regional meetings/workshops held quarterly. The activity co-ordinator for the dementia care unit has recently retired and activity assistants (two) are employed to deliver group and one on one activities in the dementia unit seven day a week from 1-7pm. The adjusted time for the activity co-ordinator in the dementia unit is a recent quality initiative and best suits the resident's recreational needs. Caregivers working in the dementia care unit include activities with residents as part of their day. Resources are readily available.

The rest home/hospital programme includes activities that meet the needs and preferences of the consumer groups. Bupa has set activities on the programme that is delivered with the flexibility to add site specific activities, entertainers and outings. The rest home/hospital programme includes one on one time for residents who are unable or choose not to participate in the programme. 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 reading, quizzes, Sit and be fit exercise programme, crafts, card games, ball games, theme days, walks, shopping, singing, reminiscing, entertainment and outings.

There is a separate programme for the residents in the dementia care unit that accommodates group and individual activities focused around cognitive, sensory and physical activities such as music, art, crafts, reminiscing, hand/foot spas/massage, household chores, gardening, walking, bowls, books, dance, exercise and poetry. There are items of memorabilia available to residents such as nursery area, typewriters, costumes etc and outdoors a garden shed and raised gardens for resident use. The residents in the dementia unit attend entertainment and activities in the rest home/hospital wings under supervision.

There are regular outings (up to three a week) for all the residents. Two staff attend outings and at least one member will have a current first aid certificate. The service has a wheelchair hoist van. Outings include scenic drives, cafes, garden centres, shopping, and picnics. There are outings to community events such as concerts, heritage week events, fashion parades, ANZAC day events, and there will be an upcoming event to celebrate the Older Persons day. Residents and staff are involved in theme days by wearing costumes and being involved in the on-site celebrations. Special occasions and birthdays are celebrated. There are volunteers involved in the service with singers visiting every week and other assisting with games, talking and reading with residents.

Church services are held twice a month. The Salvation Army visit residents regularly. The Kapa Haka group of school children also visit and entertain.

The family/resident completes a Map of Life on admission which includes previous hobbies, community links, family, and interests. The individual activity plan in all resident files sampled identify activities and community links that reflect the resident's normal patterns of life. The activity plan (incorporated into the My Day , my way long term care plan is reviewed at the same time as the care plan six monthly at the multidisciplinary review. Individual activities participation records are maintained. 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 seven of seven files sampled. 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 such as the physiotherapist. 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:

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to needs assessor, social worker, eye clinic, dietitian, physiotherapy, mental health services and wound nurse specialist.

D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care from rest home to hospital level of care.

D 20.1 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. Four relatives confirmed on interviewed they are notified and kept informed of the residents 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 main locked medication room in the hospital wing holds the main supplies, prn medications and controlled drug cabinet. The rest home wing stores its medication trolley in a locked has a locked cupboard. The dementia unit has a separate locked medication room.

Registered nurses in the hospital and caregivers in the rest home and dementia unit administer medications. All medication competent staff have completed annual medication competencies for oral administrations, controlled drugs and insulin competencies. RNs complete additional competencies for syringe driver. Medication education was delivered in February and May 2014. The service uses robotic roll system for regular and prn medications. The supplying pharmacy deliver and pick up all returns.

All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Inventory and pharmacy stock are checked weekly. PRN medications and expiry dates are checked three monthly. There is a supply of hospital stock held in the locked drug cabinet in the hospital wing. There is an antibiotic stock held for GP prescribing. All controlled drugs are checked weekly. The facility manager and clinical manager complete a stocktake of controlled drugs six monthly. The standing orders are current and meet the requirements for standing orders. All eye drops (and creams) in the three medication trolleys are dated on opening. There is a specimen and medication fridge in the rest home medication room. The medication fridge temperatures (hospital and dementia units) are checked at daily and temperatures are within acceptable ranges. Oxygen, suction and the emergency trolley is checked weekly (checklist sighted). Oxygen concentrators are available. Glucagon (within expiry dates) are held for insulin dependent diabetics.

There currently two rest home residents and one hospital resident self-administering inhalers/nasal spray. Competency assessments, responsibility and consents have been completed and reviewed by the GP or NP three monthly. Medications are stored safely in the resident's rooms. Fourteen resident medication signing sheets are sampled. Signing sheets correspond to instructions on the medication chart. PRN medications are signed, dated and timed. Controlled drugs and insulin administration is double signed on the signing sheets. The medication folder contains information on crushable medications 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. Antipsychotic medication management plans are in place for residents on these medications.

Fourteen medication profiles sampled (four dementia care, six hospital unit and four rest home) are pharmacy generated , up to date and reviewed monthly by the G.P. There are photos and allergy status documented on all 14 medication charts sampled.

16.5. e.i.2; Fourteen medication charts reviewed identified that the GP had seen the reviewed the resident 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. The cook (interviewed) has been in the role six weeks and had a three day induction with a mentor. There is a cook on duty daily from 9am-5.30pm who is supported by a morning and evening 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 each kitchenette (rest home/hospital and dementia care unit). Special diets and alternative choices for dislikes are accommodated and are labelled reading for serving. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are recorded in kitchen notebook. Special diets are written up on the kitchen notice board and include vegetarian, peanut and mushroom allergy. Normal and moulied meals are provided. Diabetic jellies and desserts are available. A nutritional requirements book is held in the dementia care unit End cooked food temperatures are recorded on each meal daily. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. The kitchen is well equipped to cater for the number of meals produced. Chemicals are stored safely however the planned renovation of the dishwashing side of the kitchen will include an inbuilt chemical cupboard. Safety data sheets are available. Cleaning schedules are maintained. Food service audits completed include; Food safety 98% and food storage 100% in August 2014.

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 available in the dementia care unit kitchenette and fridge.

D19.2; Sixteen staff (including food services staff) attended food hygiene, cleaning and chemical safety in April 2014. Two staff are scheduled to attend the national programme.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a chemical/substance safety policy. There are policies on the following: - waste disposal policy - medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics. Procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff. Staff have attended chemical safety education April 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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The building holds a current warrant of fitness which expires on 30 June 2015. Reactive and preventative maintenance occurs. There is a maintenance person on staff. A 52 week planned maintenance programme is maintained. Medical equipment including hoists and wheel-on scales have been serviced and calibrated June 2014. The hot water temperatures are monitored and maintained between 43-45 degrees Celsius. There are contractors for essential service available 25/7. Electrical testing and tagging has been completed July 2014.

The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are wide with handrails and promote safe mobility with the use of mobility aids and transferring equipment. Residents are observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating and shaded areas. There is wheelchair access to all areas. There is a designated resident smoking lounge in the rest home area.

Refurbishment of dementia corridor vinyl, rest home lounge and dining carpets, heating in the dementia unit and the rest home ensuite bathrooms has occurred since previous audit.

ARC D15.3. The five caregivers interviewed (three hospital/rest home and two dementia care) and two RNs (one rest home/hospital and one dementia care) stated that they have all the equipment referred to in care plans necessary to provide care, including electric beds, ultra-low beds, landing mats, sensor mats, shower trolleys, commodes, slide sheets, sling and standing hoists, wheel-on scales, wheelchairs, lazy boy chairs on wheels, mobility aids, continence supplies, dressing and medical supplies.

E3.4d, There are two lounge areas designed so that space and seating arrangements provide for individual and group activities.

E3.3e; There are quiet, low stimulus areas and seating alcoves 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. There is a second outdoor area with a men's shed, raised gardens and fruit trees.

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. There is a mix of rest home and hospital rooms with 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. Five residents interviewed (three hospital, two 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. The bedroom doors are wide enough to allow ambulance access if required. The five caregivers interviewed (three hospital/rest home and two dementia care) and two RNs (one rest home/hospital and one dementia care). 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 maneuver 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 lounges in each unit. Each unit has a kitchenette and dining area. The hospital has two dining areas to ensure residents requiring assistance/feeding have their dignity maintained during meals. The kitchenette in the dementia unit is secure. The service has areas with tea/coffee making facilities for families and residents as appropriate. 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 a 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 for eight hours daily. There is a defined clean/dirty area within the laundry. There is a separate clean linen and folding room. Safety data sheets for chemicals used are readily

available. Laundry and cleaning staff have attended training in chemical safety April 2014 and on-site education such as safe manual handling and infection control. Personal protective equipment is ready available in the sluice rooms. There are two dedicated cleaners who are allocated areas of work. Cleaning trolleys are well equipped. Trolleys are locked away in cleaning cupboards at the end of each day. Staff are observed to be wearing appropriate protective wear when carrying out their duties. Five residents and four relatives interviewed are happy with the laundry and cleaning services provided. Maintenance person and sometimes a contractor for the high windows clean the windows. Spot cleaning of carpet is carried out as required. Internal laundry and cleaning audits have been completed as per schedule. Corrective actions have been implemented.

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 D15.3j; D19.6

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety was last provided on 9 September 2014 (attended by 4 staff and emergency procedures training was provided on 10 September 2014 to 9 staff). Fire evacuations are held six monthly with the last fire evacuation held on 13 September 2014 and 15 staff participated in the evacuation of some residents. There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents' details. There is an approved evacuation scheme dated 15 April 2013 issued by the NZ Fire Service (sighted). The facility is well prepared for civil emergencies and has emergency lighting and BBQ's. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits. Hoists have battery packs and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas. During the tour of the facility, residents were observed to have easy access to the call bells in their bedrooms and care staff carry pagers. Staff ensure that the building is secure overnight. Reception staff and staff on duty monitor visitor entry during the day.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

<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>

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.

<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>

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p>
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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 central heating throughout the personal and communal areas. All communal rooms and bedrooms are well ventilated and light. Five residents and four family interviewed, stated the temperature of the facility is 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: FA

Evidence:

There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The 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'. Bupa has a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. There are also three monthly restraint meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what constitutes restraint and the definition of an enabler. The restraint policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy.

Currently the service has one resident in the hospital area on the restraint register for bedrails at the family's request and two hospital residents using enablers (one is using a bedrail and the other is using a bedrail and a lap belt). A register for each restraint is completed that includes a three-monthly evaluation. The restraint standards are being implemented and implementation is reviewed through internal audits (last audit 27 August 2014 with 98% compliance CAR completed), facility restraint meetings, and regional restraint meetings and at an organisational level. Staff received education on restraint management on 13 February 2014 when 12 staff attended. Education on providing care to residents who exhibit behaviours that challenge was last provided in April 2014 to 19 staff.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

Only staff that have completed a restraint competency assessment are permitted to apply restraints. All permanent staff have completed restraint competency assessments. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisational level and at a service level. The clinical manager oversees the restraint coordinator and was the previous restraint coordinator. The restraint coordinator who is a registered nurse was on night shift and not available for interview at the time of audit. The restraint coordinator has a signed job description which identifies the role expectations and reporting obligations (sighted).

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

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

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

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

Attainment and Risk: FA

Evidence:

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

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails, and lap belts). The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. Restraint authorisation is in consultation with the consumer (as appropriate) or family/whanau and the facility restraint coordinator. Restraint use is reviewed three monthly during the facility restraint meetings and also as part of the three-monthly restraint reviews.

Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring requirements are documented and the use of restraint evaluated regularly by Bupa in keeping with its intentions to minimise restraint usage. Each individual has their own register of restraint or enabler use which provides an auditable record.

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 considers the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for residents on the restraint register, and as part of their care plan review. Families are included as part of this review where possible. The restraint in use (ie the bedrails) is specifically being used at the family's request. Staff believe that the bedrails are not necessary but respect the family's wishes to assure safety.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. Reduction of restraint is an on-going target at the facility as they constantly working on the reduction of restraint within the facility every year. The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.

The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator with clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The quality committee

and the governing body is responsible for the development of the infection control programme and its annual review. There are combined infection control / health and safety and quality meetings held regularly. One staff member completing her RN competency assessment programme (and who holds an infection control certificate) is an infection control committee member. The meetings include a discussion and reporting of infection control matters, trends and quality improvements. Information from these meetings is communicated to the registered nurse weekly meetings. Minutes and graphs are available to staff.

The facility has adequate signage and hand sanitisers 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 a scabies outbreak (February 2013) that was successfully contained to the dementia unit. Relevant personnel were notified.

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 forms part of the health and safety and quality meeting structure. 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. There are regular infection control teleconferences with other Bupa infection control co-ordinators.

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 hand hygiene competency. The IC coordinator (registered nurse) has attended an annual

study day with an external infection control specialist (September 2014) and at the district health board (May 2014). Staff attended infection prevention and control education in February and April 2014 with a total of 28 staff attending

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 scabies.

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 and short term care plans are completed for all resident 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 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. Benchmarking occurs against other Bupa facilities.

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: CI

Evidence:

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. Benchmarking occurs against other Bupa facilities

Finding:

Infection control initiatives have seen the introduction of a review process and reduction of total number of catheters used; as well as focus on reduction of UTIs by regular promotion of fluid rounds and the type of fluids given, education provided through toolbox talks by IFC Committee members and RNs and feeding back information on progress to staff monthly. The service has experienced a scabies outbreak (February 2013). Relevant personnel were notified. There is a separate report outlining the outbreak management and line listing of all residents affected. The GP examined and monitored residents affected. All residents and staff were treated. Residents received education around scabies and this is evidenced in the resident meeting minutes. An improvement was identified to ensure the facility holds at least a week's supply of treatment. This has been implemented. The manager has maintained a treatment record including fleas, worms and vet checks for each animal to ensure all home animals are in good health and do not cause any harm to the residents.

Corrective Action:

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