# Bupa Care Services NZ Limited - Winara

## Current Status: 4 September 2014

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

## General overview

Winara Rest Home is part of the Bupa group and is certified to provide hospital (medical and geriatric), rest home and dementia care for up to 80 residents.

Winara’s facility manager and clinical nurse manager are well qualified for their roles. Staff turnover remains low. There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Winara. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service has addressed three of the five shortfalls from the certification audit around care planning, aspects of medication management and the environment.

Improvements continue to be required around incident reporting and interventions.

This audit identified improvements around aspects of medication management.

## Audit Summary as at 4 September 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 4 September 2014

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

### Organisational Management as at 4 September 2014

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

### Continuum of Service Delivery as at 4 September 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 4 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. |

### Restraint Minimisation and Safe Practice as at 4 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. |

### Infection Prevention and Control as at 4 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. |

# 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 - Winara |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Winara Rest Home |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 4 September 2014 | **End date:** | 5 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:** | 67 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX  | **Hours on site** | 13 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXX  | **Total hours on site** | 13 | **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** | XXXXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 26 | Total audit hours off site | 18 | Total audit hours | 44 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 12 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 81 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

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

Dated Tuesday, 4 November 2014

## Executive Summary of Audit

**General Overview**

Winara Rest Home is part of the Bupa group and is certified to provide hospital (medical and geriatric), rest home and dementia care for up to 80 residents. There are 25 dual purpose beds. On the day of audit there were ten hospital and 15 rest home residents in the dual purpose rooms, 23 (of 24) hospital residents, and 19 (of 30) residents in the dementia unit. Winara’s facility manager and clinical nurse manager are well qualified for their roles. Staff turnover remains low. There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Winara. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service has addressed three of the five shortfalls from the certification audit around care planning, aspects of medication management and the environment. Improvements continue to be required around incident reporting and interventions.
This audit identified improvements around aspects of medication management.

**Outcome 1.1: Consumer Rights**

Families are kept informed of changes in resident health. Complaints processes are implemented and complaints and concerns are managed and documented.

**Outcome 1.2: Organisational Management**

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

**Outcome 1.3: Continuum of Service Delivery**

The sample of residents’ records reviewed provides evidence the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. The previous audit finding remains around documentation of interventions to reflect the resident’s current needs. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed three monthly by the general practitioner. The previous audit finding around medication timeframes has been addressed. This audit identifies improvement around aspects of medication documentation. An activities programme is implemented across the three services by a team of activities coordinators. 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 24/7.

**Outcome 1.4: Safe and Appropriate Environment**

The building holds a current warrant of fitness. Electrical equipment is checked annually. All medical equipment is calibrated and all hoists and electric beds are checked and serviced. Hot water temperatures are monitored monthly and are at 45 degrees and below. A bathroom in the dementia unit identified at the previous audit has been repaired.

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

There is a documented definition of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. 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 with an enabler in the form of bedrails (link 1.3.6). The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service currently has four residents in the hospital assessed as using a restraint (four three lap belt, one low bed). A register for each restraint is completed that includes a three-monthly evaluation. The restraint standards are being implemented and implementation is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings.

**Outcome 3: Infection Prevention and Control**

The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 2 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting  | 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.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Five files were traced (one dementia, three hospital level residents in the dual purpose beds and one hospital) and the following was noted:a) two instances where an incident is reported in progress notes without an accompanying incident form - one related to a sacral pressure area (reported as macerated skin) - there was appropriate wound management in place; one reported a leg lesion (that had been dressed).b) two incident reports (one fall resulting in a skin tear, and one skin tear) that do not appear on the monthly reporting summary’s.  | Reported incidents are managed in the prescribed manner. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | 1)The care summaries have not been updated to include interventions for; a) use of sensor mat for hospital resident, b) painful leg and shoulder for one rest home resident and c) monitoring requirements for dementia care resident post incident of absconding, and d) the use of an enabler and monitoring requirements. 2) Hospital resident assessed as high risk for pressure areas does not have any pressure injury management and interventions documented in the long term care plan/care summary. 3) Interventions have not been documented and implemented for a) one hospital resident with frequent falls has not had a review of falls risk assessment. Falls prevention strategies identified on the accident/incident form have not been documented in the long term care plan (corrected on day of audit). Monitoring of a XXXX (as per GP notes) is not identified on the long term care plan. There is no documentation/intervention for the same resident who has had gradual weight loss since admission b) One rest home resident has had weight loss of 7.6% (April-August 2014). There is no short term care plan or interventions implemented to manage the weight loss. c) Another rest home resident on XXXXX has had 3.8kg weight loss over three months. There are no documented interventions/management for weight loss. Weekly weighs have not been commenced as per the long term care plan. The same resident has behaviour monitoring in place for reported behavioural incidents. There is no documented behaviour management plan (specific dementia needs) for the exhibited behaviours, triggers and interventions. d) There is no corrective actions or monitoring instructions in the care plan (as per reported incident) for a dementia care resident who absconded from the unit. | Ensure care plans reflect the resident’s current needs and interventions are identified and implemented. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | 1) Two of four rest home medication charts and one of six hospital medication charts did not have prescribed indication for use of prn medications. 2) There is transcribing of medications on two of four dementia care non-packaged signing sheets and for one hospital resident on controlled drugs. The dose of syringe driver medication administered is not recorded on the signing sheet.  | 1) Ensure indications for use of prn medications are prescribed on the medication chart. 2) Ensure transcribing ceases.  | 30 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Accident/incident, category ones (i.e., major resident incidents), complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is a specific policy to guide staff on the process to ensure full and frank open disclosure is available. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed across August (all service types) identified that family were notified following a resident incident on ten of the forms. The other two forms stated family did not wish to be notified of minor incidents. Incident/accident forms are audited as part of the internal auditing system and a criterion is identified around "incident forms" informing family. The audit was completed in April (2014) confirmed family notification.
At an organisational level, a residents/relatives association provides a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. Newsletters were in place at Winara. Interpreter policy and contact details of interpreters. A list of Language Lines and Government Agencies is 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
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b: Six relatives (one dementia, three hospital and two rest home) stated that they are informed when their family members health status changes.
D11.3: The information pack is available in large print and this can be read to residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints procedure (065) states ‘the facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint management record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with six residents (three hospital and three rest home) and six relatives (one dementia, three hospital and two rest home) confirm they were provided with information on complaints. Complaint forms were visible for residents/relatives in various places around the facility. There are three complaints recorded across 2014 and there is well documented investigation, follow up and resolution. There are a number of compliments recorded.
D13.3h. a complaints procedure is provided to residents within the information pack at entry

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

 Bupa Winara provides care for up to 80 residents across three service levels (rest home, hospital and dementia). Twenty-five of these beds are dual purpose and on the day of audit they had ten hospital and 15 rest home residents in them. In addition there were 23 (of 24) hospital residents and 19 (of 30) dementia residents. There is one resident reportedly under the medical component at the time of audit. There is a refurbishment programme underway in the empty rooms in the dementia unit.

Bupa's overall vision is "taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Winara 2014 quality goals include: reducing the number of skin tears by 20% and improving the gardens. Progress is reported through the quality meetings and followed through in each of the staff/other meetings.

The organisation has a clinical governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) is also tabled at this forum. Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider is also in place.

Winara is part of the central Bupa region which includes eight facilities. The managers in the region teleconference monthly and meet six monthly. A forum is held every six months (with national conference) including all the Bupa managers.

There is a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and dementia care advisor. The newsletter also includes international best practice around dementia care.

The service is managed by an experienced registered nurse who has been the facility manager at Winara since March having come from one of the other Bupa facilities. She has extensive experience both clinical and managerial. The clinical nurse manager is a registered nurse who is covering a maternity leave position (since October 2013). Support is also provided by the operations manager who visits at least once each month. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical nurse managers attend annual organisational forums and regional forums six monthly.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Winara is implementing 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 implemented 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. All facilities have a master copy of all policies & procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee 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 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 quality meetings at Winara who meet two monthly. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical nurse manager that break down the data collected across the rest home, dementia unit and hospital services, and staff incidents/accidents (also link 1.2.4.3). The service has linked the complaints/compliments process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints/compliments. The Winara infection control committee meet two monthly and the weekly reports from the facility manager cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. Health and safety committee meets two monthly and is also an agenda item at the quality committee with feedback going to staff meetings.

Winara is implementing the Bupa quality and risk management process. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Corrective actions resulting from the internal audit programme were seen to have been closed out. Issues are reported to the appropriate committee e.g. quality.

Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Winara via graphs and benchmarking reports. A monthly summary of each facility within the operations managers region is also provided for the operations manager which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators and the like throughout the year. A corrective action plan is required when an indicator exceeds the KPI rate by 3.0. Corrective action plans are seen to have been implemented and closed out (also link 1.2.4.3).

Benchmarking of key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and pressure incidence rates and staff accident and injury rates. Benchmarking of key indicators with another NZ provider has commenced. Benchmarking reports are generated throughout the year to review performance over a 12 month period.

Quality action forms are being adopted at Winara and document actions that have improved outcomes or efficiencies in the facility.

D19.3:There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for with two objectives that include a reduction of moving and handling incidents by 50%. On-going review of objectives for Winara is seen in H&S meeting minutes.
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:** PA Low

**Evidence:**

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting category one incidents. The competed form is forwarded to the quality and risk team as soon as possible (definitely within 24 hours of the event), even if an investigation is on-going. 12 incident forms were reviewed across August (all service types). All forms were completed appropriately, including clinical manager review and facility manager sign out. Five files were traced and there are instances where incidents reported in progress notes without an accompanying incident form, and completed incident forms have not been included in the monthly data. The finding from the certification audit is considered to be unmet, and is a required improvement.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. A corrective action plan is required when an indicator exceeds the KPI rate by 3.0.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Incidents are reported using the appropriate form and all reviewed are seen to have been completed appropriately. Residents are reviewed at the time of incident by a registered nurse and appropriate actions are seen to have been taken. Incident reports are reviewed by the clinical manager and included on monthly data sheets. Five files were traced (one dementia, three hospital level residents in the dual purpose beds and one hospital).

**Finding:**

Five files were traced (one dementia, three hospital level residents in the dual purpose beds and one hospital) and the following was noted:

a) two instances where an incident is reported in progress notes without an accompanying incident form - one related to a sacral pressure area (reported as macerated skin) - there was appropriate wound management in place; one reported a leg lesion (that had been dressed).

b) two incident reports (one fall resulting in a skin tear, and one skin tear) that do not appear on the monthly reporting summary’s.

**Corrective Action:**

Reported incidents are managed in the prescribed manner.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Register of practising certificates is maintained, both at facility level and website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / links). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed (clinical nurse manager – who is also the infection control coordinator, two registered nurses – one is the restraint coordinator, five caregivers, cook, diversional therapist) and all had personal file checklists. Performance appraisals are current in six files reviewed, two are not due for review and two have been scheduled for review.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time – two buddies were interviewed. Staff interviewed (five caregivers, two registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interview with the clinical nurse manager confirm the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards (sighted in files reviewed). On completion of this orientation they have effectively attained their first national certificates. From this - they are then able to continue with core competencies level three unit standards. These align with Bupa policy and procedures. There is an annual education schedule that is being implemented. There is an RN/EN training day provided through Bupa that covers clinical aspects of care - e.g. wound management. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training.

Discussion with staff and management confirm a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings. A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training and there is evidence competences are being completed as prescribed.

Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses.

There is a staff member with a current first aid certificate on every shift.

E4.5d: the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5f: 11 (of 14) caregivers have completed the required dementia standards and three caregivers are in the process of completing.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.

There is At least one RN and first aid trained member of staff on every shift. Interview with five caregivers inform the RN’s are supportive and approachable. There is a qualified diversional therapist at the facility.

Interviews with staff, residents and relatives inform there are sufficient staff to meet the care needs of the 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.)*

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bupa Winara provide rest home, hospital and dementia level of care. There is a registered nurse based in the hospital and the rest home unit where there are 10 hospital level residents in dual purpose beds. A registered nurse (RN) 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 all seven files sampled (two rest home, three hospital and two dementia care). Within three weeks, the long term care plan is developed in four of four resident files of recently admitted residents (two dementia care and two rest home). This is an improvement since the previous audit.

In seven of seven files sampled the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission within 48 hours by the contracted general practitioner (GP) in the seven files sampled. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The GP interviewed is one of two GPs contracted to provide medical services for the residents of Winara. He has over 25 years’ experience in the care of the elderly. Locum cover is provided for annual leave. Each GP visits once a week (Monday and Thursday mornings) and at any other times for RN resident concerns. There is an emergency GP at the medical centre available to do house calls during surgery hours and an on-call GP up until 10pm. Afterhours GP advice can be accessed through the afterhours Health line or ambulance admission to Wellington emergency department. The GP is positive about the service and states the RNs are well trained with good clinical assessment skills and good communication. The GP has input into the multidisciplinary reviews (MDT). There is evidence of involvement in resident files from the geriatrician, palliative care co-ordinator and psychogeriatric service.

A physiotherapist is readily available as required. A podiatrist visits regularly.

Six residents interviewed (three hospital and three rest home) stated that they and their family are involved in planning their care plan and at evaluation. Resident files included family/whanau contact records, which are completed and up to date in the seven resident files sampled. There is evidence of family notification for changes in health status, infections, incidents/accidents, GP visits, care plan reviews and challenging behaviours.

Staff 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 cover each shift and identify mobility status for each resident and any significant events that have occurred such as falls, infections and changes to health. Progress notes are written on each shift, dated, timed, and signed with designation. RN entries are also identified with a “nursing “stamp. Stamps are also used in the progress notes to identify relative contact, wound management, short term care plan and Doctors round. Seven files (two rest home, three hospital and two dementia care) identified integration of allied health and a team approach.

In the seven files an activities coordinator has completed initial activity assessments and the activities sections of the “My day, my way” long term care plans. Each resident has a “map of life” in their file completed in consultation with the resident/family as appropriate.

Tracer Methodology dementia care:

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

Tracer methodology rest home:

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

Tracer methodology hospital resident:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The registered nurses complete residents’ care plans. A care summary is readily available for caregivers. There is an improvement required to ensure care summaries are updated with changes to reflect the long term care plan interventions. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. There is documented evidence (family contact sheet and in progress notes “relative contact” stamp) of family notification when a resident health status changes. The five caregivers interviewed (two hospital, two rest home and one dementia care) and two RNs (one rest home and one hospital) stated that they have all the equipment referred to in care plans and necessary to provide care, including hoists (checked April 2014), wheel-on scales (calibrated December 2013), wheelchairs, shower chairs, electric beds, sensor mats, mobility aids, continence supplies, dressing and medical supplies.

Registered nurses stated that when something that is needed is not available, management provide this within a timely manner. Six residents interviewed (three hospital and three rest home) and six families interviewed (three hospital, two rest home and one dementia care) are complimentary of care received at the facility.

Dressing supplies are available and sighted in all units, Dressing trolleys are well stocked. All staff report that there are always adequate continence supplies and dressing supplies. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Continence management in-services and wound management in-service have been provided.

Initial wound assessment and wound management plans with on-going evaluations at the instructed frequency are in place for all skin tears, minor and chronic wounds. There are short term care plans in place for skin tears and minor wounds. Chronic wound management is linked to the long term care plans. The GP is notified and reviews chronic wounds as evidenced in the resident file of residents with chronic wounds. Photos show healing progress. There is evidence of referrals and correspondence from district nursing, ulcer clinic and Doppler results in the record of one rest home resident with a chronic leg ulcer since December 2013. There are three skin tears, four minor wounds and three residents with chronic leg ulcers in the rest home. There are three skin tears and two lacerations (scalp and eyelid – two residents with injury post falls) in the dementia care unit. In the hospital unit there are eight skin tears, six minor wounds. Pressure area resources identified in the care plans of the three residents with pressure injuries include position changes, air alternating mattresses and pressure area cushions. There is an improvement required around pressure area interventions and management for residents who are assesses as high risk for pressure injuries. RNs have attended recent wound management education August 2014.

There is a physiotherapist available by referral follows up residents post falls, equipment advice as required. The RN completes risk tool assessments on admission including continence, falls, transfer plans, pressure area risk, nutritional assessments, pain assessments, cultural assessment and dependency rating.
Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, Iowa pain monitoring tool and behaviour monitoring chart. There is an improvement required around the documentation and implementation of interventions to reflect the resident’s current needs in regards to weight management, behaviour management and falls.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The registered nurses complete residents’ care plans. A care summary is readily available for caregivers. Pressure area resources identified in the care plans of the three residents with pressure injuries include position changes, air alternating mattresses and pressure area cushions. The RN completes risk tool assessments on admission including continence, falls, transfer plans, pressure area risk, nutritional assessments, pain assessments, cultural assessment and dependency rating. Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, Iowa pain monitoring tool and behaviour monitoring chart. The registered nurses complete residents’ care plans. A care summary is readily available for caregivers. Pressure area resources identified in the care plans of the three residents with pressure injuries include position changes, air alternating mattresses and pressure area cushions. The previous audit finding remains.

**Finding:**

1)The care summaries have not been updated to include interventions for; a) use of sensor mat for hospital resident, b) painful leg and shoulder for one rest home resident and c) monitoring requirements for dementia care resident post incident of absconding, and d) the use of an enabler and monitoring requirements. 2) Hospital resident assessed as high risk for pressure areas does not have any pressure injury management and interventions documented in the long term care plan/care summary. 3) Interventions have not been documented and implemented for a) one hospital resident with frequent falls has not had a review of falls risk assessment. Falls prevention strategies identified on the accident/incident form have not been documented in the long term care plan (corrected on day of audit). Monitoring of a XXXX (as per GP notes) is not identified on the long term care plan. There is no documentation/intervention for the same resident who has had gradual weight loss since admission XXXXX. b) One rest home resident has had weight loss of 7.6% (April-August 2014). There is no short term care plan or interventions implemented to manage the weight loss. c) Another rest home resident on XXXXXX has had 3.8kg weight loss over three months. There are no documented interventions/management for weight loss. Weekly weighs have not been commenced as per the long term care plan. The same resident has behaviour monitoring in place for reported behavioural incidents. There is no documented behaviour management plan (specific dementia needs) for the exhibited behaviours, triggers and interventions. d) There is no corrective actions or monitoring instructions in the care plan (as per reported incident) for a dementia care resident who absconded from the unit.

**Corrective Action:**

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a team of four activities co-ordinators employed to implement the separate activity programmes in the rest home, hospital and special care unit. Two activity co-ordinators job share in the special care unit from 11am to 6pm over Monday to Sunday. One of the co-coordinators has completed her core competencies, dementia units and will commence the diversional therapy (DT) units in the near future. She attends the DT regional support group. There is a company occupational therapist that oversees the overall programme. Two activity co-ordinators work in the rest home/hospital units Monday to Friday. All activity co-ordinators hold a current first aid certificate and attend relevant on-site education. Bupa has set activities on the programme that is delivered with the flexibility to add site specific activities, entertainers and outings.

The programmes include activities that meet the needs and preferences of the two consumer groups however many activities are integrated. Programmes are displayed. Variations to the programme are made known to the residents. Residents may choose to participate in the group programme. One on one time is spent with residents who are unable to or choose not to participate in the group programme.

There is a full activity programme which includes (but not limited to) rest home – executive golf, news and exercises, word building, dancing, arts and craft; Hospital – one on one time, pampering, story group, reminisce, housie, musical instruments sensory activities; special care unit – sensory actives such as cooking bread, floral art, story time, reminiscence, sports charades, bowls, manicures, knitting group and involvement in household tasks. Community visitors to the facility include entertainers, ballroom dancers, senior citizens, visiting minister, pet therapy. Church services are held weekly on Sundays with rotation of the churches. Festive occasions and birthdays are celebrated. There are weekly van outings for all units. There are five volunteers (family members) who assist on outings. Two staff accompany residents on outings. All van drivers have completed van driver competencies. The residents have been creating wearable arts and on the day of audit residents from the three units are attending the Wearable Arts at the community hall to parade their costumes.

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 registers are maintained. A communication diary is used between the activity and clinical staff. Residents have the opportunity to provide feedback on the activity programme through resident meetings and resident satisfaction surveys.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Care plans are reviewed and evaluated by the registered nurse at least six monthly in six (two rest home, three hospital and one dementia) of seven files sampled. One dementia care resident has not been at the service long enough for a six monthly care plan evaluation. Six monthly multi-disciplinary team reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident. Family members are invited to attend the MDT review. The MDR checklist identifies the family member who has attended the MDR review. There is at least a one- three monthly review by the medical practitioner. There are short-term care plans available to focus on acute and short-term issues (link 1.3.6.1). Short term care plans in place sighted are for chest, wound infections and skin tears evidence 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 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies and procedures are in line with accepted guidelines. The medications are stored in a locked trolley and locked medication cupboard within the key padded nurse’s station in the rest home and dementia care units. The hospital unit has a key padded treatment room where all controlled drugs and pharmaceuticals are kept. The locked medication trolley is kept in the clinical manager locked office when not in use. Registered nurses administer medications in the rest home and hospital units. Caregivers administer medications in the dementia care unit. All medication competent staff have completed/scheduled to undertake annual medication competencies for oral administrations controlled drugs, oxygen administration. Insulin competencies are scheduled. Currently there are no residents on insulin. RNs complete additional competencies for subcutaneous fluids and syringe driver.

The service uses robotic roll system and prn are dispensed in blister packs/robotic rolls. All pre-packaged medications are checked on delivery against the medication chart and signed off on the medication reconciliation sheet. Discrepancies are fed back to the supplying pharmacy. PRN medications and pharmacy stock are checked for expiry dates regularly. All controlled drugs for the service are dispensed from the hospital controlled drug safe. The hospital level hold a controlled drug stock. All controlled drugs are checked weekly. The pharmacy completes a six monthly audit last August 2014. There is a current standing orders list signed by the two contracted GPs. All eye drops in the medication trolley are dated on opening. Medication fridges are checked at east weekly and temperatures are within acceptable ranges. Oxygen and suction is checked weekly (checklist sighted).

There are currently three rest home residents self-administering (two inhalers and one Panadol). Competency assessments, responsibility and consents have been completed for the three residents and these are reviewed three monthly and medications are stored safely. Fourteen resident medication signing sheets are sampled. Signing sheets correspond to instructions on the medication chart. PRN medications are signed, dated and timed. There is an improvement required around avoiding transcribing. Midday medication round in the hospital unit confirmed compliance of medication administering procedures.

Fourteen medication profiles sampled (four dementia care, six hospital unit and four rest home) are legible, up to date and reviewed at least three monthly by the GP. There are photos (dated) and allergy status documented on all 14 medication charts sampled. The previous finding around the prescribing of times frames for medications has been addressed. This audit identifies an improvement around indications for use of PRN medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies e) short course medications f) warfarin. There is an antipsychotic medication plan for residents with dementia on antipsychotic medication.

D16.5.e.i.2; Fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Fourteen medication profiles sampled (four dementia care, six hospital unit and four rest home) are legible, up to date and reviewed at least three monthly by the G.P. There are photos (dated) and allergy status documented on all 14 medication charts sampled. Fourteen resident medication signing sheets are sampled. Signing sheets correspond to instructions on the medication chart. PRN medications are signed, dated and timed

**Finding:**

1) Two of four rest home medication charts and one of six hospital medication charts did not have prescribed indication for use of prn medications . 2) There is transcribing of medications on two of four dementia care non-packaged signing sheets and for one hospital resident on controlled drugs. The dose of syringe driver medication administered is not recorded on the signing sheet.

**Corrective Action:**

1) Ensure indications for use of prn medications are prescribed on the medication chart. 2) Ensure transcribing ceases.

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

##### Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'. There is a monthly on-line forum for all Bupa facilities cooks. There are three kitchen staff on duty each day including a morning and evening qualified cook. The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site. Resident likes and dislikes are known and alternative choices offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Dietary preferences, likes, dislikes and special diets (diabetic, moulied) are noted on the kitchen whiteboard, which can be viewed only by kitchen staff. Two cooks interviewed confirm they are notified of resident dietary changes. Food is delivered to the unit kitchenettes in hot boxes and meals served from bain maries. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Staff are observed serving and assisting residents with their meals at lunchtime in the hospital unit. Hot food temperatures are monitored on all meals daily (records sighted). The food thermometer is calibrated six weekly. All foods are dated in the chiller and facility fridges. The service has a large workable kitchen that contains a walk-in pantry, freezer, fridges, chillers, combi-oven, bain maries, microwave and commercial baking equipment. Fridges and freezers have temperatures monitored daily. All chemicals are stored safely. The kitchen is locked after hours.
Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number of audits completed including; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit. The cooks (interviewed) receive feedback on the food service and meals from the resident meeting minutes. 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. Staff have been trained in safe food handling and chemical safety.

E3.3f; There is evidence of additional nutritious snacks available over 24 hours. There are two deliveries daily to the units of sandwiches, fruit, protein drinks, cakes, desserts etc. Snacks are sighted in the dementia care unit fridge.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a current building of fitness that expires 2 June 2015. The Bupa comprehensive maintenance schedule includes reactive maintenance and repairs and a planned maintenance programme which is up to date. Electrical equipment is tested and tagged. Medical equipment is calibrated and all hoists and electric beds are checked and serviced. Residents are observed moving freely around the areas with mobility aids where required. The external areas are well maintained with shaded seating area. Hot water temperatures are monitored on a weekly rotating basis and 45 degrees and below. The one dementia unit bathroom that required repair at the previous audit (1.4.3.4) has been addressed. This is an improvement from the previous audit.

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

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

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

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint policy (251) states the organisations philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated. The restraint co-ordinator is a RN who works across all services and all shifts. There is a job description in place that defines the role and responsibilities. There is a regional restraint group at an organisation level that meets twice yearly and reviews restraint practices. Benchmarking occurs quarterly against all facilities. The facility restraint group meets regularly and consists of two RNs, facility manager, four caregivers (one rest home and three hospital). Meeting minutes March 2014 sighted. Restraint/enablers are also discussed in the quality meetings at the facility. All residents using restraint or enablers are reviewed three monthly. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures. The service actively promotes restraint minimisation and safe practice with the use of alternative strategies (ultra-low beds, perimeter mattresses, landing pad, diversional therapy) and comprehensive assessments attempted prior to the use of restraint if clinically indicated.

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 (hospital) on the register with an enabler in the form of bedrails. The file reviewed included an enabler consent, comprehensive enabler assessment and monitoring in place. The enabler is linked to the long term care plan (link 1.3.6.1). The service has four residents in the hospital with restraints in use (two bedrails, three lap belt and one low ultra-low bed. A register for each restraint is completed that includes a three-monthly evaluation. The restraint standards are being implemented and implementation is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings.

Clinical staff receive restraint education on orientation and on-going. Staff complete a restraint competency.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

#### Standard 3.5: 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 unit manager) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.
Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and 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.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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