# Bupa Care Services NZ Limited - ParkHaven Hospital

## Current Status: 22 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

Parkhaven Hospital is part of the Bupa group. The service is certified to provide hospital (medical, and geriatric), residential disability, psychogeriatric and mental health services for up to 84 residents. On the day of the audit there are 78 residents. Parkhaven’s care home manager (non-clinical) is well qualified and has been in the role for five years. She is supported by a clinical manager who has been in the role 4 months and has had previous experience in aged care.

There are well developed systems, policies and procedures that are structured to provide appropriate care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Parkhaven. A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

The service has addressed the two previous shortfalls around documentation of spiritual care and the restraint/enabler register.

This audit identified improvements around staff being kept informed of quality data trends and outcomes, documentation of interventions in the care plans and the standing order format. .

## Audit Summary as at 22 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 22 September 2014

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

### Organisational Management as at 22 September 2014

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| 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 22 September 2014

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

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

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 22 September 2014

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

### Infection Prevention and Control as at 22 September 2014

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| 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 Service Provider Audit Report (version 6.0)

## **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 a health and disability 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**

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| --- | --- |
| **Legal entity name:** | Bupa Care Services NZ Limited |
| **Certificate name:** | Bupa Care Services NZ Limited - ParkHaven |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | ParkHaven Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Intellectual; Residential disability services - Physical; Residential disability services - sensory | | | |
| **Dates of audit:** | **Start date:** | 22 September 2014 | **End date:** | 23 September 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 78 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 2 |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 36 | Total audit hours off site | 14 | Total audit hours | 50 |

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| Number of residents/patients interviewed | 5 | Number of staff interviewed | 13 | Number of managers interviewed | 2 |
| Number of residents’/patients’ records reviewed | 9 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 98 | Number of relatives interviewed | 5 |
| Number of residents’/patients’ records reviewed using tracer methodology | 4 |  |  | Number of GPs interviewed (Residential Disability providers only) | 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:

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| --- | --- | --- |
| 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 Monday, 3 November 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Parkhaven Hospital is part of the Bupa group. The service is certified to provide hospital (medical, and geriatric), residential disability, psychogeriatric and mental health services for up to 84 residents. On the day of the audit there are 78 residents (48 hospital residents, 21 psychogeriatric residents, six residential disability and nine mental health residents). Parkhaven’s care home manager (non-clinical) is well qualified and has been in the role for five years. She is supported by a clinical manager who has been in the role 4 months and has had previous experience in aged care.  There are well developed systems, policies and procedures that are structured to provide appropriate care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Parkhaven. A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.  The service has addressed the two previous shortfalls around documentation of spiritual care and the restraint/enabler register. This audit identified improvements around staff being kept informed of quality data trends and outcomes, documentation of interventions in the care plans and the standing order format. . |

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| **Outcome 1.1: Consumer Rights** |
| Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter’s policy is in place. Family members and staff, from a range of cultures, are the most common source of interpreter services within the facility. External assistance is available if necessary. The complaints procedure is provided to residents and relatives as part of the admission process. Complaints forms are available at reception. The complaints register is up to date and includes relevant information regarding each complaint. Documentation including follow up letters and resolution demonstrates that complaints are managed. |

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| **Outcome 1.2: Organisational Management** |
| Parkhaven Hospital has an embedded quality and risk management system. Quality and risk performance is reported to the organisation's management team. There is an improvement required around staff being kept informed of quality data trends and outcomes. Parkhaven participates in the Bupa benchmarking programme with comparative data across the organisation shared for hospital, and psychogeriatric/mental health services. The service documents and analyses incidents/accidents, and unplanned or untoward events. Individual incident reports are completed for each adverse event with prompt follow-up action(s) taken as indicated.  There are human resources policies including recruitment, selection, orientation and staff training and development. A comprehensive orientation programme is in place that provides new staff with relevant information for safe work practice. There is an in-service education and training programme covering relevant aspects of care.  The organisational staffing policy aligns with contractual requirements and includes skill mixes. The 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. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Assessments, care plans and evaluations are completed by the registered nurses. Relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available, implemented and are used to assess the level of risk and support required for residents including managing behaviours. Service delivery plans demonstrate service integration and are individualised. The previous finding around inclusion of spiritual needs in the care plans has been addressed. This audit identifies an improvement required around documentation of interventions to reflect the resident’s current health status. Care plans are evaluated six monthly or more frequently when clinically indicated. There is a qualified Occupational Therapist to oversee the planned activities programme five days a week across the three levels of care. There is an activity person based in the hospital, psychogeriatric and mental health unit Monday to Friday. Caregivers also incorporate activities into their day.  There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. There are improvements required to the standing order form.  The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Food safety certificates are completed by kitchen staff. There are food service policies and procedures and a link to a dietitian. Weight management is monitored closely by the facility. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The building holds a current warrant of fitness. Electrical equipment is checked according to the planned maintenance schedule. All medical equipment is calibrated and all hoists and electric beds are checked and serviced annually. Hot water temperatures are monitored monthly. There is sufficient equipment for staff to safely deliver care. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are clear guidelines in policy to determine what a restraint is and what an enabler is. Currently the service has 14 residents using restraint and 15 residents using enablers. Education and training is provided around restraint, enablers and challenging behaviours.  The restraint register identifies the type of restraint being used and restraint processes identify any risks associated with the use of restraint. These are improvements from the previous audit.  There is one required improvement around ensuring residents in the psychogeriatric unit can move freely to their bedrooms and outside to the secure outdoor area. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. 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**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 47 | 0 | 4 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality data is analysed and results are discussed at quality meetings. Findings are not consistently discussed at staff or senior staff meetings. While the quality meeting minutes are placed on a board for staff to read, not all staff read these as evidenced in staff interviews. It is noted that benchmarking results are placed in the relevant service areas but discussions of the results with staff is not always evident. | Ensure quality improvement data results are communicated to staff. | 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | (i)The care summary for one mental health resident has not been updated to identify a recent fractured pelvis, (ii) The LTCP of two of three psychogeriatric residents did not document interventions, for (a) pain management for resident on XXXXX, and (b) change in dietary needs to low fat dietary reduction diet. | Ensure care plans reflect current needs | 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The standing order form in place dated March 2014 does not meet the MOH standing order guidelines | Ensure the standing orders form meets the guidelines | 60 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.1.1.4 | The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | Key pad access to the secure outdoor area and to the residents’ bedrooms in the psychogeriatric unit prevents them from having the ability to move freely into these areas. | Ensure the residents living in the psychogeriatric unit are able to move freely to their bedroom or to the secure outdoor area. | 180 |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Four registered nurses (RNs) (two unit coordinators and two staff nurses) and the clinical nurse manager interviewed state that they record contact with family/whanau on the family/whanau contact record (sighted). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. A sample of 15 incident forms reviewed from across all three areas (hospital, psychogeriatric and mental health) identified that family are kept informed. As part of the internal auditing system, keeping families informed is being monitored.  D16.4b The five relatives (two from the psychogeriatric unit, one from the mental health unit and two from the hospital) interviewed stated that they are kept informed when their family members health status changes or if an adverse event occurs. All five residents report that they are kept informed (evidenced in interviews with four hospital level residents and one mental health resident). There is a Bupa residents/relatives association that provides a strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician.  The interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of interpreter services (eg, Language Lines, and government agencies) is available. The clinical manager reports that he is aware of accessing interpreter services through Counties Manukau District Health Board (CMDHB) for one resident who is only able to speak in XXXXX. In addition, a number of staff are able to assist with interpreting for care delivery.  D12.1 Non-Subsidised residents/EPOA is 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. ARHSS D16.1bii; The information pack and admission agreement includes payment for items not included in the services. A site specific ‘Introduction to Dementia’ unit booklet providing information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new residents’ handbook providing practical information for residents and their families. D11.3 The information pack is available in large print and advised that this can be read to residents. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The number of complaints received each month is reported monthly to care services via the facility benchmarking spread sheet. There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and is prominent on noticeboards. Complaints forms are available in the resident information pack and in the reception area. A complaints register is up-to-date and includes relevant information regarding each lodged complaint (there have been five complaints lodged in 2014 (year-to-date). Documentation including follow-up letters or meetings and resolution demonstrates that complaints are well managed. Verbal complaints are encouraged and actions and responses are documented. Discussions with all five relatives confirmed they were provided with information on complaints and complaints forms are available at the entrance.  CMDHB received a complex complaint that was lodged in July 2013. This complaint prompted 15 corrective actions that have been signed off by CMDHB. There has been a change in management since this complaint was lodged, including a care home manager who was appointed in early 2014 and the clinical manager (RN) who was appointed in May 2014. ARHSS D13.3g: The complaints procedure is provided to relatives on admission. 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. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Parkhaven Hospital is part of the Bupa group of facilities and provides care for up to 84 residents across three service levels. There are 48 of 50 hospital - geriatric/medical residents including residents under the medical component of their certification. This includes six persons under the age of 65 under the disability support services contract. There are also 21 of 22 residents in the psychogeriatric unit and 9 of 12 residents in the mental health unit.  Parkhaven has in place an experienced care home manager. She has worked as a care home manager for Bupa for the past five years and was appointed as the care home manager at Parkhaven Hospital in early 2014. She is supported by a clinical manager (RN). The clinical manager was employed in May 2014. Prior to this appointment he worked in another aged care facility in Auckland. The clinical manager holds a post-graduate certificate in care of the older adult from Auckland University of Technology (AUT).  Bupa's overall vision is ‘Taking care of the lives in our hands’. There is an overall Bupa business plan and risk management plan. Additionally, Parkhaven Hospital has an annual quality plan. Parkhaven has set four specific and measurable quality goals for 2014. These goals are displayed in a visible location as a poster in a range of different colours to draw the attention of the staff. Quarterly quality reports on progress towards meeting these goals are completed and forwarded to the Bupa quality and risk team. Quality meeting minutes reviewed include discussing on-going progress towards meeting goals.  Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. The care home manager provides a documented weekly report to the Bupa operations manager. The operations manager visits regularly and completes a report to the director care homes.  Parkhaven continues to implement the "personal best" initiative whereby staff are encouraged to enhance the lives of residents. 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. Managers and clinical managers attend annual organisational forums and regional forums six-monthly. ARC E2.1, ARHSS D5.1 The philosophy of the service 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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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 1.2.1.3 (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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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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.)* |

#### 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Parkhaven Hospital has a quality and risk management system in place. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, on the noticeboard and to the organisation's management team. However, while quality data is analysed and results are discussed at quality meetings, findings are not always discussed at staff or senior staff meetings. While the quality meeting minutes are posted for staff to read, not all staff read these as evidenced in staff interviews. It is also noted that benchmarking results are placed in the relevant service areas but discussion of the results of these with all staff was not always evident. This is a required improvement.  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. All facilities have a master copy of all policies and procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on Bupa 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 is decided. These group members are asked to feedback on changes to policy and procedures, which are forwarded to the chair of this committee and commonly the quality and risk team. Key components of the quality management system link to the monthly quality committee through quality reports provided from departments. Weekly reports by the care home manager to the Bupa operations manager and monthly quality indicator reports to the Bupa quality management coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected and staff incidents/accidents. The service has linked the complaints process with its quality management system. There is a quarterly infection control (IC) committee at Parkhaven. Weekly reports from Bupa care home managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. The health and safety committee meets quarterly and is an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health and safety incidents are forwarded to the Bupa health and safety coordinator. Any serious incident at any facility is reported to all Bupa facilities as memos/warnings. Annual analyses of results is completed and provided across the organisation. The facility restraint meeting meets monthly as part of the quality meeting and the Bupa regional restraint approval group meets six-monthly. The 2014 resident satisfaction survey results reflect that 86% of residents are either satisfied or very satisfied with the services received. Surveys results are posted in a visible location for staff to view.  There is an implemented internal audit programme. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes.  The care home manager provides a documented weekly report to the Bupa regional manager. 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 / health & safety staff indicators etc. throughout the year.  D19.3: There is a comprehensive health & safety and risk management programme in place. Hazard identification, assessment and management policy guides practice. Bupa also has a health & safety coordinator who monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2014. On-going review of these objectives for Parkhaven is documented in health & safety meeting minutes.  D19.2g Falls prevention strategies are in place that include the analyses 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, 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Parkhaven Hospital has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, on the noticeboard and to the organisation's management team. Key components of the quality management system link to the monthly quality committee through quality reports provided from departments. Weekly reports by the care home manager to the Bupa operations manager and monthly quality indicator reports to the Bupa quality management coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected and staff incidents/accidents. The service has linked the complaints process with its quality management system. There is a quarterly infection control (IC) committee at Parkhaven. |
| **Finding:** |
| Quality data is analysed and results are discussed at quality meetings. Findings are not consistently discussed at staff or senior staff meetings. While the quality meeting minutes are placed on a board for staff to read, not all staff read these as evidenced in staff interviews. It is noted that benchmarking results are placed in the relevant service areas but discussions of the results with staff is not always evident. |
| **Corrective Action:** |
| Ensure quality improvement data results are communicated to staff. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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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.)* |

#### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3c: The service collects incident and accident data. The category one incidents policy includes responsibilities for reporting category (CAT) one incidents. The competed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going). CAT one incidents across all Bupa facilities are shared with the managers as learning opportunities. 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(s) required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect the discussion of results. Quality data is not regularly communicated with staff (link to finding 1.2.3.6). Fifteen of fifteen incident/accident reports reviewed across all areas (hospital, psychogeriatric, mental health) identified that all clinical accidents and incidents included clinical follow-up by a registered nurse with monitoring (such as neurology observations) having been undertaken when indicated.  Discussions with service management confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is documented evidence of the public health authority and district health board notified in April 2014 of a norovirus outbreak (six residents, no staff). |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A register of registered nurse and enrolled nurse practising certificates is maintained at a facility level. Within Bupa, website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / links). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were randomly selected for review (one clinical nurse manager, one registered nurse, three caregivers, and one occupational therapist). They all had signed employment contracts, job descriptions and up-to-date performance appraisals.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, registered nurse four weeks); during this period, they do not carry a clinical load. Completed orientation booklets are held in staff files. Staff interviewed (seven caregivers (five who work in the hospital and two who work in the psychogeriatric and mental health units), and four registered nurses were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Interviews with the clinical nurse manager confirmed that the caregivers, when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first (level 2) national certificates. They are then able to continue with core competencies level three unit standards. This aligns with Bupa policy and procedures.  There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care - eg. dementia, delirium and care planning. There is evidence on registered nurse staff files of attendance at the registered nurse training day/s and external training. Bupa has developed competency workbooks around core education topics. The clinical nurse manager reports he uses these to ensure staff have a full knowledge of the subject area. Discussions with staff and management confirm that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is a regular agenda item for the two-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.  D17.7d: Registered nurse competencies include (but are not limited to); assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver. There are 19 caregivers that work in the psychogeriatric unit and mental health units. E4.5f. Eighteen have achieved their dementia unit standard which includes managing challenging behaviours. One caregiver, who has been working at Parkhaven for less than six months, has commenced the course.  No staff working in mental health unit have completed a crisis prevention and intervention (CPI) course. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The 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. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours. The roster is flexible to allow for the increase of numbers of residents. The care home manager and clinical manager are available for eight hours a day, five days a week. There is a registered nurse (RN) in the hospital 24 hours per day. Five RNs (two RNs in each hospital wing and one unit coordinator) cover the hospital during the morning shift, and two RNs cover the afternoon shift. One RN covers the night shift in the hospital.  Two RNs cover the psychogeriatric and mental health units on the morning shift, one RN covers the afternoon shift and one RN covers the night shift. Note: the psychogeriatric and mental health units are in the same area (the ‘garden wing’) with the nursing office shared between both units. An EN can substitute for an RN with no more than one EN scheduled at any one time.  There are 10 caregivers working in the hospital during the morning shift (four working a full shift and six working a short shift), six caregivers during the afternoon shift (one working a full shift and two working a short shift), and three caregivers during the night shift (all full shift). In the garden wing, there are four caregivers scheduled for the morning shift (all full shifts), five caregivers in the afternoon shift (three long shifts and two short shifts) and one caregiver scheduled on the night shift. In addition, two caregiver staff work in the garden wing from 0500 – 1300. Interviews with seven caregivers (working across all three services on morning, afternoon and night shifts) confirm that staffing numbers were satisfactory. Interviews with five residents (four hospital and one mental health) and five relatives (two hospital, two psychogeriatric and one mental health) had no concerns about staffing levels. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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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.)* |

## **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The staff and facilities are appropriate for providing hospital, psychogeriatric, disability services, mental health services and respite care services.  The registered nurses complete resident assessments and risk assessments on admission. Clinical evaluations are reviewed at least six monthly or earlier due to health changes.  Nine resident files sampled (three hospital – includes one disability resident, three psychogeriatric – includes one disability resident, three mental health) identified that in nine of nine files an initial assessment was completed within 24 hours. In nine of the nine files sampled, the long term care plan was completed within three weeks. The long term care plan is evaluated six monthly. Care summary forms are completed for quick reference for care staff (link 1.3.6.1). Relatives interviewed (two hospital, two psychogeriatric and one mental health) confirmed they are involved in the care planning progress. Residents interviewed (four hospital and one mental health) state they are involved in their individual care plans. Seven care staff (five hospital and two psychogeriatric and mental health services) who work across all shifts described comprehensive handovers for all RNs and the caregiving team at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. There is a written handover sheet and verbal handover. Progress notes are written every shift.  Medical assessments are completed on admission by the general practitioner (GP) with two working days in six of six residents files sampled. Medical reviews are at least three monthly or earlier as indicated by the GP. The GP has input into the six monthly reviews. The GP interviewed practices independently and has been providing medical services to the residents at Parkhaven for 12 years. The GP visits daily Monday to Friday to visit any residents of concern. One to three monthly reviews are scheduled. Families/whanau are invited to meet with the GP for discussion and concerns regarding their relative’s health. A locum GP is arranged to cover for GP leave. The GP is available 24/7 for his patients. The GP stated there are no concerns with enrolling new patients. He readily accesses the mental health services as required. The GP states RN clinical assessments are good and all calls made to him are appropriate. The GP is very positive about the delivery of care and physiotherapy service at Parkhaven. He states it is a very good facility.  Physiotherapist is contracted to the service for four hours a day.  Three mental health resident files sampled. NASC assessments are sighted in three of three files evidence the residents require mental health service level of care. The mental health services for older people (MHSOP) have both planned and as required input. The psychiatric district nurse (PDN) visits Parkhaven weekly, and a psychogeriatrician visits monthly and does a review including anti- psychotic management.  ARHSS D16.6; Three psychogeriatric resident files reviewed include behaviours that challenge identified on admission through the assessment process with triggers for behaviours, interventions and management documented in a behaviour plan in all three files reviewed. Behaviour charts are in use to monitor new or acute behaviours. The care plan contains ‘specific dementia needs’ that identify activities and alternative strategies for de-escalation. There is evidence of a mental health services for the older persons assessments and follow-ups as required. The psychiatric district nurse visits regularly as evidenced in allied health notes and is readily available to nursing staff for support and advice as required.  Tracer methodology: hospital level resident  *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology: Psychogeriatric resident with dementia  *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology: hospital level younger person with physical disability.  *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology: Resident in mental health unit.  *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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### **Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)**

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

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

##### **Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)**

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Three of three files sampled from the mental health unit have a long term care plan which documents the residents preferences and includes interventions for all identified needs including the management of mental health symptoms. A risk assessment has been completed by the mental health service for older people. There were documented early warning signs or relapse prevention plans. In one of three files the resident’s affairs were managed by the public trust and there was a Person Order current until 2016. In two of three files sampled there was evidence of family involvement in reviews and care. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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.

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

##### **Criterion 1.3.5.4 (HDS(C)S.2008:1.3.5.4)**

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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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.)* |

#### 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents’ care plans are completed by the registered nurses in all areas. The care being provided is overall consistent with the needs of residents. In all nine resident files sampled (three hospital, three psychogeriatric and three mental health) resident spiritual and cultural needs identified on admission and in the activity assessment completed. Resident cultural and spiritual needs are documented in the long term care plan. This is an improvement since the previous audit.  Care delivery is recorded and evaluated by registered nurses (RNs) and caregivers on each shift (evidenced in all nine residents' files progress notes sighted – three from the mental health unit, three from the psychogeriatric unit and three from the hospital). Comprehensive short term care plans are used for changes to the mental health resident’s care or mental health status. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The seven caregivers interviewed (five hospital and two psychogeriatric/mental health services) stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoists (checked March 2014), wheelchairs, mobility aids, shower trolley, sensor mat, landing pads, sensor mats, chair scales, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted.   Five residents interviewed (four hospital, one mental health) and five relatives (two psychogeriatric unit, one mental health unit and two from the hospital) were complimentary of care received at the facility. During the tour of and time spent in the facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. 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. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. Wound assessment and wound management plans are in place for three skin tears, two leg ulcers, three minor wounds and three pressure areas (one resident with sacrum pressure area and one resident with a hip and heel pressure area) in the psychogeriatric unit. There are four skin tears, one chronic ulcer, three minor wounds, one donor site and a surgical wound in the hospital unit. All wounds are linked to residents care plans. There are no pressure areas in the hospital unit. There are no skin tears or wounds in the mental health unit. Wound management education is scheduled for 26 September.  Risk assessments are completed on admission as applicable including continence, falls, and pressure area, nutrition, challenging behaviour, pain assessments and physiotherapy assessments. Pain and the effectiveness of pain relief is monitored with the use of an Iowa pain assessment tool and documented in the progress notes. Resident’s weight is monitored monthly. Weight loss is reported and the GP notified. Documented interventions include a review of dietary requirements, type of diet, assistance with meals as required, dietary supplements, nutritious snacks, finger foods and alternative choices are offered. The kitchen manager (interviewed) states she is informed of any residents losing weight. There is evidence of dietitian referrals and recommendations have been followed. The dietitian visits two monthly or earlier if required.  There is an improvement required around the documentation of interventions in the care plan to reflect the resident’s current health status.  ARHSS D16.4; There is regular mental health service for the older person and community psychogeriatric service input into the care and medication review of residents in the psychogeriatric unit. The psychiatric district nurse follows-up residents with regular visits and liaises closely with the mental health team. There is evidence of specialist and community team input in allied health notes held in the resident files of three of three psychogeriatric residents files sampled.   Strategies for the provisions of a low stimulus environment could be described. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents’ care plans are completed by the registered nurses in all areas. The care being provided is generally consistent with the needs of residents. Five residents interviewed (four hospital, one mental health) and five relatives (two psychogeriatric unit, one mental health unit and two from the hospital) were complimentary of care received at the facility. |
| **Finding:** |
| (i)The care summary for one mental health resident has not been updated to identify a recent XXXXX, (ii) The LTCP of two of three psychogeriatric residents did not document interventions, for (a) pain management for resident on XXXXXX, and (b) change in dietary needs to low fat dietary reduction diet. |
| **Corrective Action:** |
| Ensure care plans reflect current needs |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)**

The consumer receives the least restrictive and intrusive treatment and/or support possible.

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

##### **Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)**

The consumer receives services which:  
(a) Promote mental health and well-being;  
(b) Limit as far as possible the onset of mental illness or mental health issues;  
(c) Provide information about mental illness and mental health issues, including prevention of these;  
(d) Promote acceptance and inclusion;  
(e) Reduce stigma and discrimination.   
This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A registered occupational therapist (OT) is employed full-time to activity programme for the three services. There is a team of activity assistants who implement the Monday to Friday programme in the hospital, psychogeriatric and mental health unit. The activity assistants have completed levels in career force and dementia course and hold 1st Aid certificates. Each area has a dedicated activity assistant. The OT has a monthly consultation meeting with the activity assistants to plan the monthly programme for each area ensuring activities planned relate to the physical, cognitive, intellectual and sensory needs/abilities of the groups of residents. The OT completes the initial assessment for all residents and is involved in the six monthly multidisciplinary reviews that includes the review of the activity plan and care plan at the same time. Caregivers integrate activities into their day with the residents. There are adequate resources available in each area.  The programme in the psychogeriatric and mental health unit allows for flexibility and spontaneity. One on one time is spent with residents in the hospital, psychogeriatric and mental health unit as some residents choose not to or are unable to participate in the group programme. One on one activities include (but not limited to); hand and nail pampering, massage, reminiscence, sensory activities, doll and pet therapy. Visiting families with children add to the family environment. There are two home cats and the OT brings in her friendly dog regularly offering pet therapy to residents as observed on day of audit. The hospital programme includes (but not limited to); board games, music, news, exercise (B-fit programme), bowls, baking, walking group and one on one time/room visits. There are two activity assistants based in the Gardenview wing (psychogeriatric and mental health unit). They deliver many and varied activities dependent on the abilities and needs of the residents including (but not limited to); board games, reading group, colouring and painting, wheelchair walks, dancing, ball games, musical instruments, beauty sessions, ball games, singing and music. Entertainment is scheduled monthly. Staff play guitar and lead sing-a-longs (sing star) as observed and enjoyed by residents who joined in (mental health unit). The service has a wheelchair hoist van and there are two outings a week for residents in each unit. There is a designated van driver and an activity assistant on outings. Church services are held every two weeks. Church visitors are arranged to see individual residents as required or on request.   The OT is involved in the activity assessment for the younger person with disabilities. The OT (interviewed) states the activity plan is tailored to meet the individual needs of the resident. Examples of individual activities include; attending art classes in the community, shopping outings, computer access to Facebook and social networking. Each younger person has individual interests and hobbies they are encouraged to maintain. One younger person has an area set up at the local marae so that they can stay overnight. The younger persons can choose to integrate with the hospital/psychogeriatric programme. A resident activities participation record is maintained. Each resident has a “map of life” developed in consultation with the resident/family/whanau as appropriate.   ARHSS 16.5g.iii: A comprehensive social history is completed on or soon after admission and information gathered, is included in the activity plan. The activity plan is developed with the relative (and resident as able) and this is reviewed at least six monthly. ARHSS 16.5g.iv: Caregivers are observed at various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.  The 2014 resident survey (including feedback from the younger persons) resulted in a 85% satisfaction for meaningful activities. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Support plans are reviewed and evaluated by the registered nurse at least six monthly or more frequently when clinically indicated as sighted in six of nine files sampled three from the mental health unit, three from the psychogeriatric unit and three hospital unit) (link 1.3.6.1). There is at least a one- three monthly review by the medical practitioner.  There are short term care plans to focus on acute and short-term issues and these are evaluated regularly. Changes to the long term care plan are made as required and at the six monthly review if required. The multidisciplinary review involves the RN, care workers, GP, Occupational Therapist, resident/family/whanau as appropriate and any other allied health professionals involved in the residents care. Family interviewed confirm they are invited to the six monthly reviews.  Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur as sighted in three of three mental health files sampled. There is at least a one monthly review by the medical practitioner. There are short term care plans to focus on acute and short-term issues. Changes to the long term care plan are made as required and at the six monthly review if required. The example of a STCP in use in the mental health area was for a pelvic fracture.  ARC: ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### **Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)**

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents leaving the mental health unit have been transferred to another unit at Parkhaven. The registered nurses at Parkhaven interviewed report when a resident is transferred from the mental health unit to another unit a comprehensive handover is provided and that many staff work between the units and know the residents well |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a medication room in the hospital unit and a locked medication stock in the shared nurse’s office between the psychogeriatric unit and mental health unit. All medication trolleys are locked. Returns are stored safely until collected by the supplying pharmacy. Regular medications are dispensed in robotic rolls fortnightly. All medications are checked on delivery by the RN on duty. Robotic checking forms are completed (sighted). PRN medications are dispensed in bottles. PRN supplies and expiry dates are checked weekly. The hospital unit holds hospital level of medications and an antibiotic imprest supply for GP prescribing. Standing orders are in place with a standing order supply for hospital and psychogeriatric residents. There is an improvement required around the standing order form. There is a register of medication competent staff. RNs and enrolled nurses only administer medications and complete medication competencies for oral medication administration, controlled drugs and insulin. Two RNs check insulin administration. RN’s complete syringe driver competencies. Each medication room has a controlled drug safe. There are weekly controlled drug checks and six monthly pharmacy checks (last completed July 2014). Glucagon is kept in the medication fridge (monitored weekly) for the treatment of hypoglycaemia. There is information on the management of hypoglycaemia in the medication folders. There is pharmacy information on crushable medications. Emergency equipment such as oxygen, suction, airways and concentrators are available and checked daily. All clinical equipment has been checked/calibrated March 2014. There are no self-medicating residents. All eye drops in trolleys are dated on opening.  Twelve medication charts sampled (six mental health, six psychogeriatric and six hospital) are all pharmacy generated and meet the legislative requirements. All medication charts have photo identification and allergies/adverse reaction noted. The GP reviews the medications monthly and the psychogeriatric consultant reviews medications three monthly or more often as required. Blood levels are monitored for residents on some medications such as dilantin and sodium valporate. Psychogeriatric residents on antipsychotic medications have an antipsychotic medicine management plan in place that is reviewed monthly.  Six of six medication charts sampled in mental health, are all correctly signed as per GP prescription. Each resident has an antipsychotic management plan. The service is proactive in reducing the use of antipsychotic medication. The resident (where appropriate) and family/whanau are consulted regarding the commencement, review and discontinuation of medications.  All six medication charts had photo identification and allergy status noted. There is evidence of one to three monthly GP and consultant review of medications. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a medication room in the hospital unit and a locked medication stock in the shared nurses office between the psychogeriatric unit and mental health unit. All medication trolleys are locked. The hospital unit holds hospital level of medications and an antibiotic imprest supply for GP prescribing. Standing orders are in place with a standing order supply for hospital and psychogeriatric residents. |
| **Finding:** |
| The standing order form in place dated March 2014 does not meet the MOH standing order guidelines |
| **Corrective Action:** |
| Ensure the standing orders form meets the guidelines |
| **Timeframe (days):** 60 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### **Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)**

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **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 teleconference forum for all Bupa facilities cooks. There is a kitchen manager/cook and second cook on duty each day who are supported by three kitchen assistants who work shifts up until 9pm. The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site. The service has moved to pre-prepared vegetables (with the exception of potatoes for which there is a machine) due to reported issues with repetitive syndrome among kitchen staff carrying out vegetable preparation. The kitchen manager reports the kitchen staff have seen an improvement in their health recently. The kitchen receive nutritional forms for all resident on admission and kitchen notification forms for any dietary changes/requirements. Resident likes and dislikes are known and alternative choices offered. The kitchen manager is trialling a variation in tea meals due the current wastage from the evening meals. Feedback on the meals is received through resident meetings, verbal feedback and surveys. The 2014 survey shows an increase from 76% (2013) to 81 % food satisfaction. The kitchen staff provide special duets such as no uric acid, gluten free, low fat, high calorie (for weight loss), normal, diabetic desserts, normal and soft/moulied meals. Meals are transported to the hospital dining room in a bain marie ready for serving. Meals for the psychogeriatric and mental units are plated and delivered in scan boxes. Special diets are labelled. Lip plates and specialised utensils are provided to promote and maintain independence with meals.  End cooked hot food temperatures are monitored on all meals daily (records sighted). All foods are dated in the chiller, freezer and facility fridges. Fridges and freezers have temperatures monitored daily and there is evidence of corrective action where temperature are outside of the acceptable range. Dishwasher rinse temperature is checked daily on the final rinse. All chemicals are stored safely in a locked cupboard. Staff have been trained in chemical safety. Staff are observed to be wearing correct personal protective clothing when carrying out their duties.  There are a number of audits completed including; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit. The kitchen manager/cook (interviewed) receives feedback on the food service and meals from the resident meeting minutes, head of department and kitchen meetings. 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.   D19.2: All kitchen staff have current food safety certificates. The kitchen manager is in the process of completing a workplace assessor certificate.  ARHSS D15.2f: There is evidence that there is additional nutritious snacks available in the psychogeriatric unit over 24 hours. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The building has a current warrant of fitness that expires 16 March 2015. There is a full-time maintenance person responsible for internal and external building maintenance. The hot water temperatures in rooms and resident areas have been fluctuating between 30 and 43 degrees Celsius. The service is currently installing new gas boilers for all hot water and radiator heating. The temperatures will be computer controlled. There are 24/7 contractors available for essential services. Clinical equipment has had annual checks. Electrical equipment is tested and tagged March 2013.  ARHSS D15.3d. The lounge area is designed so that space and seating arrangements provide for individual and group activities. The nursing station is shared between the psychogeriatric unit and mental health unit that allows observation of all residents in the communal area.  ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses and cushions, shower chairs, lifting and standing hoists, mobility aids, weighing scales and electric beds.  ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.  ARHSS D15.3b: There is a safe and secure outside area with seating and shade (link 2.1.1.4).  The mental health unit has open lounge and dining areas with a smaller separate home-like lounge set up with memorabilia and items of interest. There is an outdoor garden and seating area (conservatory) for the residents in the unit. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Restraint policy states the philosophy is 'we are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated".  There is a regional restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures.  The restraint and enabler registers identify the residents using restraint and the types of restraint in use. Restraint and enabler use and associated risks are linked to the residents’ care plans. This is an improvement from the previous audit. The service has fifteen residents using an enabler (ten lap belts, four bed rails and one low bed as a cultural enabler). Fourteen residents are using a restraint (ten bed rails, and four lap belts). The two files reviewed of the residents with an enabler-included assessment, consent, interventions and three monthly evaluations. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level. Environmental restraint is in place when entering and exiting the psychogeriatric unit and mental health unit with appropriate consent and assessment processes in place.   Access codes are also required for residents to go outside to a secure courtyard and to go to the bedroom wing in the psychogeriatric unit. This is a required improvement. Access into the hospital unit is via a visible green push button with signage in place in a visible location adjacent to the button and on the opposite wall. Residents and visitors are able to freely enter and exit the facility. There are two day care residents with dementia who are at risk of absconding. The push button to exit the facility is beyond their capability and keeps them safe and secure in the hospital wing. Their files were reviewed and included assessments, consents, and three monthly evaluations. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The restraint and enabler registers identify the residents using restraint and the types of restraint in use. Types of restraint and enabler use and any risks associated with restraint are documented and are linked to the residents’ care plans and the staff education and competency on restraint use. This is an improvement from the previous audit. The service has fifteen residents using an enabler (ten lap belts, four bed rails and one low bed as a cultural enabler). Fourteen residents are using a restraint (ten bed rails, and four lap belts). Two files were reviewed of residents using an enabler and included assessments, consents, interventions and three-monthly evaluations. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level. Environmental restraint is in place when entering and exiting the psychogeriatric unit and mental health unit with appropriate consent and assessment processes in place. Access codes are also required for residents to go outside to a secure courtyard and to go to their bedroom wing. This is a required improvement for the psychogeriatric unit. Access into the hospital unit is via a visible green push button with signage in place in a visible location adjacent to the button and on the opposite wall. Residents and visitors are able to freely enter and exit the facility. There are two day care residents with dementia who are at risk of absconding. The push button to exit the facility is beyond their capability and keeps them safe and secure in the hospital wing. Both of their files were reviewed and included environmental restraint assessments, consents, and three-monthly evaluations. Monitoring is in place for these two residents. |
| **Finding:** |
| Key pad access to the secure outdoor area and to the residents’ bedrooms in the psychogeriatric unit prevents them from having the ability to move freely into these areas. |
| **Corrective Action:** |
| Ensure the residents living in the psychogeriatric unit are able to move freely to their bedroom or to the secure outdoor area. |
| **Timeframe (days):** 180 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems in place are appropriate to the size and complexity of the facility. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator and reported at the quality, staff and infection control meetings. Definitions of infections are in place appropriate to the complexity of service provided. 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 facility 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, laboratory service and head office that advice and provide feedback /information to the service. There are regional infection control meetings and regular Bupa teleconference for infection control co-ordinators. The service engages in benchmarking with 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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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 3.6.4 (HDS(IPC)S.2008:3.6.4)**

Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |