

# Bupa Care Services NZ Limited - Ascot House

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Current Status: 29 September 2014

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

## General overview

Ascot Care Home is part of the Bupa group and was opened November 2013. The building of Ascot care home was completed in two stages and is now fully complete. The service is certified to provide rest home, hospital (including medical) and dementia level care for up to 104 residents. On the days of the audit there were 74 residents: 29 rest home residents, 29 hospital level residents and 16 residents in the dementia unit. Ascot care home currently has a relieving care home manager who has been relieving manager at Bupa Ascot since 11 August 2014. A new manager is commencing mid October 2014.

Staffing levels continue to grow as resident numbers increase. There are well-developed Bupa systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Ascot Care Home. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The service was initially certified to provide psychogeriatric level of care in the 24 bed secure unit – however the service has withdrawn from the provision of this type of service. The secure unit (20 beds approved) is now a dementia level unit.

This audit identified that improvements are required in relation to advanced directives, provision of orientation for caregivers to activities in the dementia unit, provision of a training programme for caregivers, completion of care plans and GP visits within expected timeframes, consistent delivery of an activities programme in the dementia unit, aspects of medication management, provision of shade in the outdoor areas and reporting of outbreaks.

## Audit Summary as at 29 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

Indicator	Description	Definition
	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 29 September 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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### Organisational Management as at 29 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 29 September 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 29 September 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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## Restraint Minimisation and Safe Practice as at 29 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 29 September 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 29 September 2014

### Consumer Rights

Ascot Care Home endeavours to provide care in a way that focuses on the individual residents' quality of life. Residents and relatives overall spoke very positively about care provided at Ascot Care Home. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. An improvement is required in relation to advanced directives. Complaints processes are implemented; complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### Organisational Management

Ascot Care Home has commenced implementation the Bupa quality and risk management system. Key components of the quality management system link to a number of meetings including quality meetings. A resident/relative satisfaction survey has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Quality data is collected and improvements are actioned. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Ascot Care Home is benchmarked against hospital, rest home and dementia. There is an improvement required around essential notification.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme for new staff with relevant

information for safe work practice. An improvement is required in relation to orientation of caregivers to the dementia unit activities programme. There is an in-service training programme which is being delivered and covers relevant aspects of care and support. External training is well supported. An improvement is required whereby a caregiver training programme is implemented. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

### **Continuum of Service Delivery**

The service has an admission policy and process. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around initial care plans, long term care plans and general practitioner admissions being completed within the required time frames.

Medication policies reflect legislative requirements and guidelines. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There are improvements required around competency reviews for those resident self-medicating, GP prescriptions and signing sheet documentation.

The activities programme is facilitated by an activities team and residents and families report satisfaction with the activities programme. The programme includes significant community engagement including visits with other aged care facilities in the area. An activities plan is developed by the activities co-ordinator for the dementia unit. There is an improvement required regarding implementing and delivering the activity programme in the dementia unit.

All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

### **Safe and Appropriate Environment**

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for rest home level residents. External areas are safe and well maintained. An improvement is required in relation to provision of shade in the outdoor areas. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and

emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has central heating and temperature is comfortable and constant.

### **Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service currently has two residents assessed as requiring restraint and no residents using enablers. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

### **Infection Prevention and Control**

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training and is supported by the Bupa quality and risk team. Infection control training is provided at least twice each year for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

<b>Legal entity name:</b>	Bupa Care Services NZ Limited
<b>Certificate name:</b>	Bupa Care Services NZ Limited - Ascot House
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Ascot Care Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	<b>Start date:</b> 29 September 2014 <b>End date:</b> 30 September 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	74

## Audit Team

<b>Lead Auditor</b>	XXXXXX	<b>Hours on site</b>	16	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXX	<b>Total hours on site</b>	16	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	32	Total audit hours off site	13	Total audit hours	45
Number of residents interviewed	12	Number of staff interviewed	15	Number of managers interviewed	6
Number of residents' records reviewed	9	Number of staff records reviewed	8	Total number of managers (headcount)	4
Number of medication records reviewed	18	Total number of staff (headcount)	72	Number of relatives interviewed	16
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Friday, 31 October 2014

## Executive Summary of Audit

### **General Overview**

Ascot Care Home is part of the Bupa group and was opened November 2013. The building of Ascot care home was completed in two stages and is now fully complete. The service is certified to provide rest home, hospital (including medical) and dementia level care for up to 104 residents. On the days of the audit there were 74 residents: 29 rest home residents including one respite, 29 hospital level residents including two respite and 16 residents in the dementia unit. Ascot care home currently has a relieving care home manager who has been relieving manager at Bupa Ascot since 11 August 2014. A new manager is commencing mid October 2014.

Staffing levels continue to grow as resident numbers increase. There are well-developed Bupa systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Ascot Care Home. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The service was initially certified to provide psychogeriatric level of care in the 24 bed secure unit – however the service has withdrawn from the provision of this type of service. The secure unit (20 beds approved) is now a dementia level unit.

This audit identified that improvements are required in relation to advanced directives, provision of orientation for caregivers to activities in the dementia unit, provision of a training programme for caregivers, completion of care plans and GP visits within expected timeframes, consistent delivery of an activities programme in the dementia unit, aspects of medication management, provision of shade in the outdoor areas and reporting of outbreaks.

### **Outcome 1.1: Consumer Rights**

Ascot Care Home endeavours to provide care in a way that focuses on the individual residents' quality of life. Residents and relatives overall spoke very positively about care provided at Ascot Care Home. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. An improvement is required in relation to advanced directives. Complaints processes are implemented; complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### **Outcome 1.2: Organisational Management**

Ascot Care Home has commenced implementation the Bupa quality and risk management system. Key components of the quality management system link to a number of meetings including quality meetings. A resident/relative satisfaction survey has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Quality data is collected and improvements are actioned. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Ascot Care Home is benchmarked against hospital, rest home and dementia. There is an improvement required around essential notification.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme for new staff with relevant information for safe work practice. An improvement is required in relation to orientation of caregivers to the dementia unit activities programme. There is an in-service training programme which is being delivered and covers relevant aspects of care and support. External training is well supported. An improvement is required whereby a caregiver training programme is implemented. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

### **Outcome 1.3: Continuum of Service Delivery**

The service has an admission policy and process. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around initial care plans, long term care plans and general practitioner admissions being completed within the required time frames.

Medication policies reflect legislative requirements and guidelines. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There are improvements required around competency reviews for those resident self-medicating, GP prescriptions and signing sheet documentation.

The activities programme is facilitated by an activities team and residents and families report satisfaction with the activities programme. The programme includes significant community engagement including visits with other aged care facilities in the area. An activities plan is developed by the activities co-ordinator for the dementia unit. There is an improvement required regarding implementing and delivering the activity programme in the dementia unit.

All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

**Outcome 1.4: Safe and Appropriate Environment**

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for rest home level residents. External areas are safe and well maintained. An improvement is required in relation to provision of shade in the outdoor areas. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has central heating and temperature is comfortable and constant.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service currently has two residents assessed as requiring restraint and no residents using enablers. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

**Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training and is supported by the Bupa quality and risk team. Infection control training is provided at least twice each year for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	43	0	6	1	0	0
<b>Criteria</b>	0	92	0	6	3	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0	0	0	0

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	Four residents did not evidence that advanced directives had been completed (two rest home and two hospital).	Ensure that advanced directives are completed for those residents able to make decisions.	90
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.				
HDS(C)S.2008	Criterion 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.	PA Low	There has not been notification to the public health department or the DHB following a respiratory infection outbreak, however, the IC co-ordinator advised reporting the outbreak to the DHB and public health department on the day of the audit	Ensure that appropriate personnel are advised of any outbreaks in a timely manner	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Orientation of care staff to the dementia unit, and in particular to the activities and diversional therapy programme, is not evidenced in staff files reviewed (confirmed on dementia unit caregiver interviews). Currently, the	Provide evidence that care staff working in the dementia unit received training and orientation specific to providing activities and diversional therapies.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				diversional therapist does not work in the dementia unit. Care staff are expected to implement the activities programme during the morning and afternoons (link #1.3.7.1).		
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Three caregivers working in the dementia unit have not commenced the dementia unit standards. They have been employed at Ascot care home for longer than six months.	Ensure that all care staff working in the dementia unit have commenced dementia unit standards training within six months of employment and completed with 12 months of employment.	60
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	(i)One hospital resident does not show evidence that the initial care plan has been completed within 48 hours, (ii) Four residents (one rest home, one hospital and two dementia) do not show evidence that the long term care plan has been developed	(i)Ensure that all initial care plans are completed within 48 hours. (ii) Ensure that all long term care plans are developed within three weeks. (iii) Ensure that all resident are admitted by the GP within two working days.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				within three weeks. (iii) Two residents (one rest home and one hospital) do not show evidence that the GP has admitted the resident within two working days.		
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The activity programme for the dementia unit is not consistently being implemented/delivered.	Ensure that the activity programme in the dementia unit is consistently delivered by either the caregivers or the activities co-ordinator.	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where	PA Moderate	Three residents self-administering medication do not show evidence that	Ensure that all residents self-administering medications have	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		appropriate.		competencies to self-administer have been reviewed three monthly.	competency assessments reviewed three monthly.	
HDS(C)S.2008	Criterion 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.	PA Moderate	(i) Three medication charts have not been reviewed by the GP three monthly (two from the rest home and one from the hospital). (ii) One resident having oxygen therapy does not have this charted on the medication chart by the GP and staff are signing that this is being given.	(i) Ensure that all resident have a three monthly medication review by the GP and this is documented. (ii) Ensure that all medications are charted and that staff only administer medications that are prescribed by the GP.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	There is currently no provision of shaded areas for residents to access when utilising the outside areas e.g. gardens and courtyards (either natural or from umbrellas or shade cloths).	Provide shaded areas for residents to access when utilising the outside areas.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about 'The Code' at induction (orientation for new staff conducted on 28 November 2013 prior to opening), new staff also complete a code of rights and advocacy participants workbook (competency) as part of orientation and as part of the in-service training programme (not yet delivered). Staff files reviewed (eight) evidence completed code of rights and advocacy questionnaires/competency. Interviews with eight caregivers (four dementia, one rest home and three hospital), one enrolled nurse and two registered nurses showed an understanding of the key principles of the code of rights.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. There are translators available for any resident who does not speak English.

On entry to the service, the relieving care home manager or clinical manager discusses the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available at reception. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Interviews with 12 residents (eight rest home and four hospital) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints. Interviews with 16 relatives (six rest home, four hospital and six dementia) confirmed they are informed of the code of rights.

### Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)**

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

**Attainment and Risk:** FA

**Evidence:**

During the tour of the facility, respect for privacy and personal space was demonstrated. Resident files are held in the three locked nurses' offices. Interview with caregivers could explain ways resident privacy is maintained. Interviews with 12 residents (eight rest home and four hospital) confirmed that privacy is ensured.

The August 2014 resident/relative satisfaction survey identified that 96% of residents stated privacy was either excellent or very good.

Resident information includes Bupa vision and values. Residents and relatives interviewed were positive about the service in respect of considering and being responsive to meeting values and beliefs.

D4.1a: Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery (confirmed on interviews). An initial care planning meeting six weeks after admission is carried out, whereby the resident/family are invited to be involved - cultural/religious would be again considered at this time. Interviews with residents confirmed that cultural beliefs and values were respected by staff. There are a multi-cultured staff at Ascot Care Home.

Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, what to wear, getting up, meal times and meal alternatives) and that staff are obliging around choice. There is one married couple at Bupa Ascot who share a room and use another room as their private sitting area. One of these residents interviewed advised that he appreciates being able to live with his wife and that their privacy is respected.

The Bupa Personal Best programme has yet to be fully implemented at Ascot Care Home. Training for staff on the implementation of the programme was delivered in June 2014 with 12 attendees and is a quality objective for the current year. The programme enables staff to have a greater understanding of their own team members; cultures, experiences and individual abilities. It provides staff with an increased customer focus and commitment which in turn provides person centred care. Personal Best programme is designed to help employees develop their skills in considering residents and think about how they can treat and care for them as individuals. It focuses on

recognising and rewarding all employees who put the resident at the centre of everything they do. The Personal Best programme is driven by the management team. Care plans reviewed identified specific individual likes and dislikes. There is a question around 'choice' in the resident/relative satisfaction survey. A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training was delivered as part of the orientation training day for 12 new staff (November 2013) and again in June 2014 where 23 staff attended. Any incidents of alleged abuse are taken very seriously by management and staff. D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Person centred care/individuality and independence training is provided to staff annually. D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Personal belongings are documented and included in resident files.

#### **Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)**

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)**

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

**Attainment and Risk:** FA

**Evidence:**

A3.2 There is a Maori health plan which includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)  
D20.1i the Bupa Maori health policy was first developed in consultation with Kaumatua and is utilised throughout Bupa's facilities. The CDHB Tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Local Iwi and contact details of Tangata whenua are identified.  
Special events and occasions are celebrated at Ascot Care Home and this could be described by staff. There are no residents at Ascot who identify as Maori. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process.  
Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member's stay/care. Cultural awareness and Maori health education will be provided as part of the annual education programme and is scheduled to occur in November 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with 16 relatives (six rest home, four hospital and six dementia) all identified that values and beliefs were considered. Discussions with 12 residents (eight rest home and four hospital) all stated they believed staff took into account their culture and values.

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

D4.1c: Nine resident's files were reviewed (three rest home, three hospital and three dementia) and all included the resident's social, spiritual, cultural and recreational needs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. There is policy to guide staff practice: Gift, Gratitude's and Benefits, Delegations of Authority. Registered nurses meeting (monthly) includes any discussions on professional boundaries and concerns. The clinical manager also provides regular memo's to registered nurses if there any concerns or reminders about responsibilities and code of conduct. Advised that management provide guidelines and mentoring for specific situations. Interviews with eight caregivers (four dementia, one rest home and three hospital), one enrolled nurse, two registered nurses, and the clinical manager, described professional boundaries.

### **Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)**

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

**Attainment and Risk:** FA

### **Evidence:**

Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Ascot Care Home is currently benchmarked in two areas – rest home and hospital. A quality improvement programme is implemented that includes performance monitoring. Graphs and data is provided to Ascot Care Home staff on the noticeboard and corrective actions completed when trends are evident or areas are above the benchmark. Corrective action plans have been established and evaluated for effectiveness.

Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates.

ARC A2.2: Services are provided at Ascot Care Home that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring.

ARC D1.3: all approved service standards are adhered to.

All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.

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

Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan (sighted with quality meeting minutes). Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation.

ARC D17.7c There are implemented competencies for caregivers, enrolled nurses and registered nurses. Competencies are completed for key nursing skills at Ascot Care Home including (but not limited to); a) moving & handling, b) wound care, c) assessment tools and d) medication. RNs have access to external training.

Discussions with residents and relatives at Ascot Care Home were overall positive about the care they receive.

### **Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)**

The service provides an environment that encourages good practice, which should include evidence-based practice.

**Attainment and Risk:** FA

### **Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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.

The clinical manager, two registered nurses and one enrolled nurse interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for August 2014 identified that the sample of incident forms demonstrated that family were notified.

As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was completed in May 2014 at Ascot Care Home with a result of 94%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b: The 16 relatives interviewed stated that they are always informed when their family members health status changes.

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. There is also a Bupa NZ communications manager. This person's role is to keep people informed and engaged about Bupa NZ's strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.

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

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

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

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are procedure information sheets available including (but not limited to); a) minor skin surgery, b) catheterisation, and c) sub cut fluids.

Required consent forms were evident on nine resident files reviewed (three from the rest home, three from the hospital and three from the dementia unit).

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

There is an advance directive policy. The Bupa care services resuscitation of resident's policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The "decisions relating to cardiopulmonary resuscitation" pamphlet and advance directive form will be given to the resident and completed. The medical resuscitation treatment plan and resuscitation advance directive will be completed as soon as possible after admission (no more than six weeks).

Completed resuscitation treatment plan forms were evident on all nine resident files reviewed and two residents (one hospital and one rest home) evidenced advanced directives completed. This is an area requiring improvement of which the service has identified and is working through ensuring all files evidence advance directives where appropriate.

D13.1 There were nine admission agreements sighted and nine had been signed.

D3.1.d Discussion with 16 families (six from the rest home, four from the hospital and six from the dementia unit) identified that the service actively involves them in decisions that affect their relative's lives.

### **Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)**

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

**Attainment and Risk:** PA Low

**Evidence:**

There is an advance directive policy. The Bupa care services resuscitation of resident's policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The "decisions relating to cardiopulmonary resuscitation" pamphlet and advance directive form will be given to the resident and completed. The medical resuscitation treatment plan and resuscitation advance directive will be completed as soon as possible after admission (no more than six weeks). Completed resuscitation treatment plan forms were evident on all nine resident files reviewed and two residents (one hospital and one rest home) evidenced advanced directives completed.

**Finding:**

Four residents did not evidence that advanced directives had been completed (two rest home and two hospital).

**Corrective Action:**

Ensure that advanced directives are completed for those residents able to make decisions.

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

### **Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

**Attainment and Risk:** FA

**Evidence:**

Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with eight caregivers (four dementia, one rest home and three hospital), one enrolled nurse and two registered nurses described how residents are informed about advocacy and support. Interviews with 12 residents (eight rest home and four hospital) confirmed that they are aware of their right to access advocacy.

D4.1d; Discussion with 16 family members (six rest home, four hospital and six dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

ARC D4.1e, Nine resident files reviewed included information on resident's family/whanau and chosen social networks.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Visitors were observed coming and going during the audit. There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census.

D3.1.e: Interviews with 12 residents (eight rest home and four hospital) confirmed that the activity staff help them access the community such as going shopping, attending appointments and visiting.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet.

There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with 12 residents (eight rest home and four hospital) and 11 relatives confirmed they were provided with information on complaints and complaints forms. Complaints received so far for 2014 were reviewed and included three written complaints and three verbal complaints. All were well documented including investigation, follow up letter and resolution.

E4.1biii. There is written information on the service philosophy and practices particular to the dementia 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Bupa Ascot Care Home provides rest home, hospital (including medical), and dementia specific care for up to 104 residents. The facility is divided into four x 20 bed wings for rest home and hospital residents (all dual purpose beds) and a 24 bed secure dementia unit. One of the 20 bed rest home/hospital level wings is yet to be occupied. On the days of the audit there were 74 residents: 29 rest home residents including one respite, 29 hospital level residents including two respite and 16 residents in the dementia unit. Under the medical component of their certification, there was one resident under the age of 65 with a chronic long term medical condition. Initially the 24 bed secure unit was built as psychogeriatric unit (D6), however, due to a low demand for this level of care in the area the service has changed the service level to dementia specific as of 30 June

2014. There are no psychogeriatric residents remaining in the dementia unit. The unit is able to be divided in to two x 12 bed care areas with dividing doors, however, this formation restricts resident's ability to wander freely about the unit. The service has applied to run the unit as a 24 bed unit (currently only 20 beds approved).

Ascot care home currently has a relieving care home manager who has been at Bupa Ascot since 11 August 2014. A newly appointed care home manager is commencing in mid-October 2014 (not interviewed). The relieving care home manager has over 30 years' experience in aged care and management and has been a full time relieving manager for Bupa since November 2013. Staffing levels continue to grow as resident numbers increase.

The relieving care home manager provides a documented weekly report to the Bupa regional operations manager. The operations manager visits regularly and completes a report to the general manager of Care Homes. Ascot care home is part of the southern Bupa region which currently includes 11 facilities. The managers in the region teleconference weekly. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Ascot Care Home and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on-going progress to meeting their goals. A forum is held every six months (with national conference including all the Bupa managers).

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

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

The clinical manager at Ascot care home has been in the role since April 2014 and is experienced in aged care and management. She is currently supported by a relieving clinical manager who provides support, peer support and advice. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

ARC, D17.3di the manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. The relieving care home manager has attended the Bupa training days and participates in meetings, regional meetings and professional development.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The relieving care home manager has been in the role since 11 August 2014 and is employed by Bupa to cover temporary manager absences. A newly appointed care home manager is due to commence employment in mid-October 2014. Advised by the regional operations manager and the relieving care home manager that she will receive a comprehensive hand over and orientation to the service.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to residents that require rest home, hospital (including medical) and dementia level care. The service consults with the Bupa occupational therapist (interviewed), dementia care advisor (interviewed), physiotherapist, dietitian, and mental health for older people services.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Ascot Care Home has implemented a comprehensive quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Bupa policies and procedures have been implemented throughout the year. All facilities have a master copy of all policies & procedures 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 their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the Quality and Risk team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule.

Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and clinical/care home managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk

systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the monthly quality meeting at Ascot Care Home. Weekly reports by relieving care home manager to Bupa operations manager and quality indicator reports to Bupa quality manager 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 resident data and staff incidents/accidents. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. There is a monthly infection control (IC) committee meeting at Ascot Care Home. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. Health and safety committee meets as part of the staff meeting and is also an agenda item at the quality committee.

Ascot Care Home has set specific quality goals for 2014 including (but not limited to): ensuring all staff have been orientated/inducted thoroughly; ensure best practice in place for the dementia unit; implementation of the Bupa systems; and introduction and promotion of the Bupa B-fit programme for staff.

Each goal is reviewed monthly and there is evidence to show that the service is working positively toward achievement. Review of all quality goals and quality initiatives are held as part of the quality meetings as well as progress with CAP's, benchmarking and KPI's. Apart from the annual quality plan developed for the service, there are a number of quality initiatives currently being implemented. These have been developed in response to audits, feedback, incidents and staff input and are updated and reviewed each month. Quality initiatives and corrective actions include addressing falls rate, medication errors, and the rate of UTI's and incidence of bruising. Further quality improvements include improving the system of laundry collection, instigation of a walking train for rest home residents, and setting up of activities corners in the dementia unit.

The service has established Corrective Action plans (CAP) where incidents/infections are above the benchmark. Audit summaries and action plans are completed where a noncompliance is identified. Memos are also provided to staff around corrective actions required. Progress with quality goals is posted in the staff room along with benchmarking graphs, incidents and infection rates. Care staff interviewed confirmed that they are involved and included in the quality processes.

Full staff meetings are held monthly (minutes reviewed for 16 September 2014), quality meetings are held monthly (minutes sighted for 23 September 2014), resident and family meetings are held two monthly (18 September 2014), a combined health and safety and infection control meeting is held monthly (19 September 2014), registered nurses meet three times per year (11 September 2014), restraint review committee meets three monthly (September 2014). Other meetings include kitchen and housekeeping, and activities. Ascot Care Home has a daily senior management meeting where issues such as resident care needs, occupancy, staffing, rosters, education, laundry, hygiene and food service are discussed.

The service collects data to support the implementation of corrective action plans. The internal audit schedule is being implemented. A resident and relative survey has been conducted (August 2014) with corrective actions in place in response to identified issues including outdoor furniture, activities programme and designated coordinator in the dementia unit, and increase of a short shift in the hospital area when numbers increase. Discussion on these issues have been conducted at the resident meeting held in September 2014. Responsibilities for corrective actions are identified.

D19.3: There is an H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has an H&S coordinator whom monitors staff accidents and incidents.

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

**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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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 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The completed 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).

Incident forms reviewed for August 2014 include a sample for rest home, hospital and dementia residents. The sample included eight rest home resident reports, eight hospital and 14 dementia resident related reports. Review of reports identified that all incident forms identified clinical follow up by a registered nurse/clinical manager and monitoring (such as neuro orbs) having been undertaken when indicated. Incident reports included falls, skin tears, category one incident, pharmacy packaging error, medication errors, pressure areas (two x one resident nearing end of life), and challenging behaviours.

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

Discussions with service management, overall confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has not been notification to the public health department or the DHB following a respiratory infection outbreak, however, the IC co-ordinator advised reporting the outbreak to the DHB and public health department on the day of the audit

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

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

**Attainment and Risk:** PA Low

**Evidence:**

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

**Finding:**

There has not been notification to the public health department or the DHB following a respiratory infection outbreak, however, the IC co-ordinator advised reporting the outbreak to the DHB and public health department on the day of the audit

**Corrective Action:**

Ensure that appropriate personnel are advised of any outbreaks in a timely manner

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

### **Evidence:**

Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links). The service has implemented the Bupa orientation programme that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time. One recently employed caregiver advised that she was orientated for a total of eight shifts covering morning, afternoon and night.

Staff interviewed (eight caregivers (four dementia, one rest home and three hospital), one enrolled nurse and two registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. However, improvements are required in relation to orientation of care staff to the dementia unit and in particular, to the activities and diversional therapy programme.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (the clinical manager, one rest home/hospital registered nurse, one registered nurse from the dementia unit, three caregivers (one who works across all areas, one dementia caregiver, and one rest home/hospital caregiver), the diversional therapist, and cook). All staff files included a personal file checklist that is maintained. Appraisals are up to date.

Interviews with the relieving care home manager and clinical manager (responsible for orientation and education) 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 national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures). There are 39 caregivers at Ascot Care Home. Many of these staff have obtained caregiving qualifications in previous employment. Improvements are required whereby a caregiver training programme is provided at Ascot care home and caregivers in the dementia unit complete the appropriate dementia unit standards within the expected time frames.

E4.5f: There are nine caregivers that work in the dementia unit. Three have completed the required dementia standards, six are yet to start. Three of these have commenced employment in the past six months. Three are overdue for commencing the dementia unit standards training.

There is an annual education schedule that is being implemented. Staff have access to the Bupa tool box talks if and when required. Topics include infection control, falls prevention, food safety, and documentation, prevention of bruising, hand washing, and medication management. There is an RN training day provided through Bupa that covers clinical aspects of care. Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. Registered nurses at Ascot have commenced their PDRP.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place.

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 were aware of the requirement to complete competency training.

D17.7d: RN competencies include: assessment tools, BSLs/Insulin administration, controlled drug administration, moving and handling, nebuliser use, oxygen administration, restraint, wound management, PEG feeds, catheterisation, syringe driver use and sub-cut fluids.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service has implemented the Bupa orientation programme that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time. One recently employed caregiver advised that she was orientated for a total of eight shifts covering morning, afternoon and night. Staff interviewed (eight caregivers (four dementia, one rest home and three hospital), one enrolled nurse and two registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (the clinical manager, one rest home/hospital registered nurse, one registered nurse from the dementia unit, three caregivers (one who works across all areas, one dementia caregiver, and one rest home/hospital caregiver), the diversional therapist, and cook). All staff files included a personal file checklist that is maintained. Appraisals are up to date. Interviews with the relieving care home manager and clinical manager (responsible for orientation and education) 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 national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures).

**Finding:**

Orientation of care staff to the dementia unit, and in particular to the activities and diversional therapy programme, is not evidenced in staff files reviewed (confirmed on dementia unit caregiver interviews). Currently, the diversional therapist does not work in the dementia unit. Care staff are expected to implement the activities programme during the morning and afternoons (link #1.3.7.1).

**Corrective Action:**

Provide evidence that care staff working in the dementia unit received training and orientation specific to providing activities and diversional therapies.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is an annual education schedule that is being implemented. Staff have access to the Bupa tool box talks if and when required. Topics include infection control, falls prevention, food safety, and documentation, prevention of bruising, hand washing, and medication management. There is an RN training day provided through Bupa that covers clinical aspects of care. Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. Registered nurses have commenced their PDRP. Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. 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 were aware of the requirement to complete competency training. Advised that caregiver training will be provided via the Career Force programme. Two staff are booked to attend assessor training for this

programme. The programme has yet to be provided at Ascot care home. There are nine caregivers working in the dementia unit. Three have completed dementia unit standards. Three have not commenced training but have been employed for less than six months.

**Finding:**

Three caregivers working in the dementia unit have not commenced the dementia unit standards. They have been employed at Ascot care home for longer than six months.

**Corrective Action:**

Ensure that all care staff working in the dementia unit have commenced dementia unit standards training within six months of employment and completed with 12 months of employment.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

The relieving care home manager (registered nurse) works fulltime Monday to Friday and is available on call after hours. She commenced her relieving role on 11 August 2014.

The clinical manager works Monday- Friday 40 hours per week and is supported by a Bupa relief clinical manager.

There is RN cover 24/7. The diversional therapist works full time and develops a programme for all three service levels (link # 1.3.7). Advised by the operations manager that is in the intention of the service to employ a designated activities staff member in the dementia unit when occupancy reaches 20 residents. There is a registered nurse rostered on in the dementia unit each shift Monday to Sunday.

A review of rosters evidenced adjustments to the roster to cover for staff sickness, annual leave, change in residents and increase in occupancy. There are designated kitchen, cleaning and laundry staff. One wing of 20 beds in the rest home/hospital area is currently closed and is not occupied. As resident occupancy numbers increase, so too will the rostered staffing levels.

Eight caregivers (four dementia, one rest home and three hospital), one enrolled nurse, two registered nurses, 12 residents (eight rest home and four hospital) and 16 relatives confirmed that there are adequate levels of staff to meet the resident's needs.

**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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time.</p> <p>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked room or secure storage for unused files.</p> <p>All resident records contain the name of resident and the person completing.</p> <p>Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p> <p>D7.1: Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</p>

**Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)**

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

### Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

**Attainment and Risk:** FA

**Evidence:**

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service.

Information gathered at admission is retained in resident's records. Twelve residents (eight rest home and four hospital) and 16 family members (six rest home, four hospital and six dementia) interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.

E4.1.b There is written information on the service philosophy and practices particular to the unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract.

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Three resident files from the dementia unit were reviewed and all includes a needs assessment as requiring specialist dementia care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

#### **Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)**

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

#### **Evidence:**

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

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission in eight (three rest home, two hospital and three dementia) of nine files sampled. This is an area requiring improvement. Within three weeks the long term care plan is developed in four (one from the rest home, two from the hospital and one from the dementia) of eight files sampled. One rest home resident is on respite care. This is an area requiring improvement.

In eight of nine files sampled (two from the rest home, three from the hospital, and three from the dementia unit) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse (one rest home resident is on respite care and does not require a long term care plan). Medical assessments are completed on admission by the GP in six of nine files sampled (one from the rest home, two from the hospital and three from dementia). One rest home resident is on respite care. This is an area requiring improvement. Six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities co-ordinator and any other relevant person.

Activity assessments and the activities sections care plans have been completed by a diversional therapist.

Twelve residents interviewed (eight from the rest home and four from the hospital) stated that they and their family were involved in planning their care plan. Resident files included family contact records which were completed and up to date in nine resident files sampled.

D16.2, 3, 4: The nine files sampled (three from the rest home, three from the hospital and three from the dementia unit), identified that in eight of nine files an assessment was completed within 24 hours and four of nine files identify that the long term care plan was completed within three weeks (one rest home resident is on respite care). There is documented evidence that the care plan were reviewed by an RN and amended when current health changes. Two (rest home) of nine care plans evidenced evaluations completed at least six monthly (six residents have been at the service less than six months and one resident is on respite care).

D16.5e: Six of nine resident files reviewed identified that the GP had seen the resident within two working days (one rest home resident is on respite care). It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

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

The care plan summary policy (371) states "the care plan summary is completed by the registered nurse within one week of admission. It is a summarised account of the cares a resident needs and will be used by caregivers to ensure care delivery is in line with the long term care plan. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change)". Staff could describe a verbal handover at the end of each duty that maintains a continuity of service

delivery. Nine files identified integration of allied health and a team approach is evident in the nine files. The GP interviewed spoke positively about the service and describes very effective communication processes.

Eight of nine files have at least an initial physiotherapy assessment with on-going assessments as necessary (one rest home resident is on respite care).

The service has completed a clinical file audit in September 2014 with 80% compliance and has a corrective action plan to address areas identified including meeting time frames for initial care plan, long term care plans and GP admissions.

Tracer Methodology hospital:

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

Tracer Methodology rest home:

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

Trace Methodology dementia:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission in eight (three rest home, two hospital and three dementia) of nine files sampled. This is an area requiring improvement. Within three weeks the long term care plan is developed in four (one from the rest home, two from the hospital and one from the dementia) of eight files sampled. One rest home resident is on respite care. This is an area requiring improvement.

In eight of nine files sampled (two from the rest home, three from the hospital, and three from the dementia unit) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse (one rest home resident is on respite care). Medical assessments are completed on admission by the GP in six of nine files sampled (one from the rest home, two from the hospital and three from dementia). One rest home resident is on respite care. This is an area requiring improvement. Six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities co-ordinator and any other relevant person.

**Finding:**

(i) One hospital resident does not show evidence that the initial care plan has been completed within 48 hours, (ii) Four residents (one rest home, one hospital and two dementia) do not show evidence that the long term care plan has been developed within three weeks. (iii) Two residents (one rest home and one hospital) do not show evidence that the GP has admitted the resident within two working days.

**Corrective Action:**

(i) Ensure that all initial care plans are completed within 48 hours. (ii) Ensure that all long term care plans are developed within three weeks. (iii) Ensure that all resident are admitted by the GP within two working days.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bupa Ascot has implemented the Bupa assessment booklets and care plan templates for all residents. The assessment booklet provides very in-depth assessment tools including; falls, Braden, skin, mini nutritional, continence, pain, dependency and activities. The falls assessment section also includes additional risk factors, for example; vision, mobility, behaviours, environment and continence.

Risk assessment tools and monitoring forms are reviewed at least six monthly and are used to effectively assess level of risk and required support for residents including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, mini nutritional assessment, incontinence assessment, behaviour assessment, skin assessment, dependency rating and wound assessment.

The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information.

Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours (# link 1.3.3.3). Continuing needs/risk assessments are carried out by a suitably qualified nurse.

All nine files sampled (three from the rest home, three from the hospital and three from the dementia unit ) contain assessments including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, skin assessment, MNA, incontinence assessment, behaviour assessment, and wound assessment (where appropriate).

Assessments and support plans are comprehensive and include input from allied health. The assessment booklet includes input from team members.

Notes by GP and allied health professionals are evident in resident's files, significant events, communication with families and notes as required by registered nurses. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met.

E4,2a: Challenging behaviours assessments are completed.

### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**Attainment and Risk:** FA

**Evidence:**

The sample of six files were reviewed.

Service delivery plans (care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health.

Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Assessments completed on admission within 24 hours are comprehensive as evidence in eight of nine files sampled (# link 1.3.3.3). The long-term care plan is completed within three weeks as evidence in four of nine files sampled (# link 1.3.3.3) with GP involvement within 48 hours as evidence in six of nine files sampled (# link 1.3.3.3). Plans are well described, include all identified needs and are reflected in the progress notes. Overall residents' care plans reviewed on the day of the audit provide evidence of individualised support.

Twelve residents interviewed (eight rest home and four hospital) and 16 families interviewed (six from the rest home, four from the hospital and six from the dementia unit) confirm care delivery and support by staff is consistent with their expectations.

There is a long term care plan that includes; a) hygiene, b) medical, c) skin and pressure area care, d) bladder and bowels, e) mobility, f) food and fluids, g) rest and sleep, h) communication, i) emotional well-being, j) spirituality, k) religion and culture, and l) activities.

Care plans demonstrate service integration. The assessment booklet includes input from team members including the activities co-ordinator (diversional therapist).

Notes by GP and allied health professionals, significant events, communication with families are included in the sample group of resident's files.

E4.3: Three resident files reviewed from the dementia unit identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k; Short term care plans are in use for changes in health status.

D16.3f; Nine resident files reviewed identified that family were involved.

**Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents' care plans are completed by the registered nurses in all three areas. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all nine residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The eight caregivers interviewed (one from the rest home, three from the hospital and four from the dementia unit) stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, 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. Twelve residents interviewed (eight from the rest home and four from the hospital) and 16 families interviewed (six from the rest home, four from the hospital and six from the dementia unit) were complimentary of care received at the facility.

The care being provided is consistent with the needs of residents, this is evidenced by discussions with eight caregivers interviewed, 16 families, two registered nurses (one from the hospital, one from the dementia unit) and one enrolled nurse from the rest home, the care home manager and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status.

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-service is scheduled for October 2014 and wound management in-service has been provided (February 2014).

Wound assessment and wound management plans are in place for 13 residents (two rest home, six hospital and four dementia) with 15 wounds. All wounds have been reviewed in the timeframe stated.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

The facility has registered nurse cover 24/7 and has an 'in service' education programme.

A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by an R.N.

During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is one activity co-ordinator who is a registered diversional therapist. The activities co-ordinator has been at the service since January 2014 and works 35.5 hours per week Monday-Friday. The activities co-ordinator is on the New Zealand executive board of diversional therapists (three years) and has a background in activity employment for 10 years. She was the diversional therapy conference convenor for the conference this year (August 2014) and meets every two months with the local diversional therapy group. The activities co-ordinator provides activities in the hospital and rest home and plans activities for the dementia to be run by the caregivers, however the activity programme for the dementia unit is not consistently being implemented/delivered. This is an area requiring improvement. The activities co-ordinator has training around dementia care and needs. On the day of audit residents in the rest home and hospital areas were observed being actively involved with a variety of activities. A music DVD entertained residents in the dementia unit, however no other activity was observed. The programme is developed monthly and displayed in large print. There are two programmes, one for the hospital/rest home and one for the dementia unit. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.

The programme includes networking within the community with social clubs, schools, weekly church services, RSA visits, and senior citizens visits, shopping and visits to other aged care facilities. On or soon after admission, a social history is taken and information from this is fed into the long term plan and this is reviewed six monthly as part of the long term care plan review/evaluation. A record is kept individual residents activities. There are recreational progress notes in the resident's file that the activity co-ordinator completes for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in all areas of the facility, participation is voluntary. Activities included but not limited to: outings in the services van, walking train, crafts music, entertainment and quizzes. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs. Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit which are conducted by care staff out of normal hours. There is a resource cupboard in each of these units where caregivers (or visitors) can access activities to complete with residents.

There is a regional Bupa occupational therapist (OT) that visits the service frequently (present on the day of the audit) who provides support and guidance around activity for residents. The monthly programme is reviewed by the regional OT. There is an activity meeting monthly (minutes sighted for September 2014).

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The activities co-ordinator provides activities in the hospital and rest home and plans activities for the dementia to be run by the caregivers. The programme includes networking within the community with social clubs, schools, weekly church services, RSA visits, and senior citizens visits, shopping and visits to other aged care facilities. There is a wide range of activities offered that reflect the resident needs in all areas of the facility, participation is voluntary. Activities included but not limited to: outings in the services van, walking train, crafts music, entertainment and quizzes. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs. Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit which are conducted by care staff out of normal hours. There is a resource cupboard in each of these units where caregivers (or visitors) can access activities to complete with residents.

**Finding:**

The activity programme for the dementia unit is not consistently being implemented/delivered.

**Corrective Action:**

Ensure that the activity programme in the dementia unit is consistently delivered by either the caregivers or the activities co-ordinator.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least a one- three monthly review by the medical practitioner. Care plans are evaluated by the registered nurses six monthly ( as evidence in two rest home files) or when changes to care occur as sighted in all nine files sampled (three from the rest home, three from the hospital and three from the dementia unit).

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. From the sample group of resident's notes the short term care plans are well used and comprehensive. Examples of STCPs in use included; infections, wounds, challenging behaviours, and unexplained weight loss.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)**

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

**Attainment and Risk:** FA

**Evidence:**

Of the sample group of notes all of the residents/EPOA had signed the informed consent and had copies of the Code of Rights. Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietician, mental health services, wound specialist and hospital specialists.

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

D 20.1 Discussions with registered nurses identified that the service has access to NASC, mental health services for older people, occupational therapists, speech language therapists, hospital specialists and dieticians.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

### **Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)**

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)**

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies and procedures align with current best practice and guidelines. The medications are stored in locked trolleys in locked treatment rooms in each of the three areas. Controlled drugs are stored in a locked safe in the treatment room in the hospital and only the registered nurses have access to controlled drugs and two people

(one being an R.N) must sign controlled drugs out. Regular weekly controlled drug checks have been completed. Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications.

The service uses two weekly robotic packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Robotic medications are checked on arrival by two registered nurses and any pharmacy errors are recorded and fed back to the supplying pharmacy.

There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Registered nurses and enrolled nurses are peer reviewed annually and caregivers are selected by the clinical manager and trained in medication administration and competency checked annually. Only those staff deemed competent administer medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off.

All 'medication competent' staff is responsible for medication administration in all areas. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers

Medication management was held in June 2014 with 17 staff attending.

Medication – self-administration policy (098) states self –administration of medication will be documented in the residents care plan.

There are currently five rest home residents self-administering medications. Two residents have completed competency assessments and these have been reviewed three monthly. This is an area requiring improvement.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P as evidence in 10 of 18 charts sampled (four residents have been at the service less than three months and one resident is on respite care). This is an area requiring improvement. One resident having oxygen therapy does not have evidence that the GP has prescribed this on the medication chart. This is an area requiring improvement. Signing sheets correspond to instructions on the medication chart for 17 of 18 medication charts sampled. This is an area requiring improvement. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name.

Medication charts are easy to read and current. Medication audits are completed six monthly (September 2014 with 71% compliance).

There is a quality goal at an organisational level to reduce the use of antipsychotics and this has recently been introduced at Bupa Ascot recently. This includes PRN medication and they are monitoring their residents to enable them to remove the medication completely.

All 18 charts sampled have PRN medications charted with indication for use documented. All eye drops are dated on opening. One enrolled nurse (from the rest home), one registered nurse (from the hospital) and one caregiver (from the dementia unit) were observed safely and correctly administering 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication – self administration policy (098) states self-administration of medication will be documented in the residents care plan. There are currently five rest home residents self-administering medications. Two residents have completed competency assessments and these have been reviewed three monthly.

**Finding:**

Three residents self-administering medication do not show evidence that competencies to self-administer have been reviewed three monthly.

**Corrective Action:**

Ensure that all residents self-administering medications have competency assessments reviewed three monthly.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P as evidence in 10 of 18 charts sampled (four residents have been at the service less than three months and one resident is on respite care). One resident is having oxygen therapy (rest home). Signing sheets correspond to instructions on the medication chart for 17 of 18 medication charts sampled.

**Finding:**

(i) Three medication charts have not been reviewed by the GP three monthly (two from the rest home and one from the hospital). (ii) One resident having oxygen therapy does not have this charted on the medication chart by the GP and staff are signing that this is being given.

**Corrective Action:**

(i) Ensure that all resident have a three monthly medication review by the GP and this is documented. (ii) Ensure that all medications are charted and that staff only administer medications that are prescribed by the GP.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'.

The national menus have been audited and approved by an external dietitian.

The service employs six kitchen staff including two cooks. The main cook has been at the service since December 2013 and has a background in cooking and hospitality. The main cook works Monday-Friday 8am-4.30pm. The main kitchen supplies meals for the hospital, rest home and the dementia unit. Each area has a serving kitchen where food is served from a baine marie.

All of the kitchen team at the service have completed food safety certs and food services training is scheduled for October 2014.

The service has a large workable kitchen that contains 1 walk-in pantry, three freezers, one walk in fridge, one other fridge, combe-oven, gas hob, deep fryer and three baine maries. There is a preparation area and receiving area. All food in the fridges, freezers and pantry is dated and labelled. Kitchen fridge, food and freezer temperatures are monitored and documented daily. There is a task schedule for kitchen staff to complete. Resident annual satisfaction survey includes food and a food service audit

completed in August 2014 has 100% compliance. There are a number audits completed include; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit.

The kitchen produces large print menus with pictures of the main meal each day to make them more able to be understood by residents.

There is nutrition assessment and management policy (347) and a weight management policy (079).

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets, low fat, low salt, vegetarian and diabetics. There are lipped plates, sipper cups and special cutlery available. Residents were observed during the audit in the dining rooms enjoying their meal with assistance from staff as required observed.

There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, and dishwashing, waste disposal and safety.

Daily temperature checks of chiller, freezers, bain marie and dishwasher are maintained.

Bupa Care Homes introduced in 2010 a comprehensive food services programme that specifically targeted all areas of the food service as a quality improvement initiative throughout the business and is being implemented at Bupa Ascot. This was in response to further improving on client satisfaction results with the service as identified through resident/relative satisfaction surveys. Achievements of the programme which continues in 2014 includes, monthly teleconferences with the chefs/cooks employed in each home, development of Bupa's own Recipes and Library of these and the review and update of all kitchen policies and procedures. Other activities included the development of "assisted eating posters" which a "Master chef" DVD with Annabelle White, a dementia specific focus included emphasis on use of coloured crockery and suitable tasty finger foods and a streamline national food contract supply for meat, groceries and vegetables. The programme also developed food safety training PowerPoint's to augment the internal core education programme within care homes. A senior chef within the business provides support and mentorship to the cooks in each of the homes. Bupa kitchen staff complete unit standard 167 Food safety training.

E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours including platters of finger food.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Chemical/substance safety policy (048) at Ascot care home guides all staff in the management of all waste and hazardous substances. There are policies on the following: - waste disposal policy which covers the disposal of medical waste, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics. There is a procedure for disposal of sharps containers. Management of waste, chemical safety and hazardous substances is covered during orientation of new staff (conducted for new staff prior to occupancy on 28 November 2013) and subsequent training sessions have been held in April and May 2014 around chemical safety. All chemicals are clearly labelled with manufacturers labels. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated on interview a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and are evident in all areas of the facility. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a maintenance person who works full time and on call at Bupa Ascot care home. Reactive and preventative maintenance occurs. There is a 52 week maintenance schedule for general, interior and exterior maintenance and service. There are hazard registers for nursing, outside areas, inside areas, cleaning and laundry. There is maintenance log book which staff can add to and issues are actioned by the maintenance person. The maintenance person advised that he has access to subcontractors who were involved in the building of Ascot care home, including plumbers, gas fitters and electricians. Fire equipment is checked by an external provider. The building holds a three month certificate of public use which expires on 30 September 2014. Electrical equipment has been tested and tagged (15 April 2014) and this is conducted two yearly. All medical equipment has been calibrated and checked by BV medical and all hoists and electric beds were checked and serviced at this time (August 2014). The maintenance person also conducts monthly checks of each hoist and sling. Hot water temperatures are checked fortnightly in each of the wings and records sighted evidence that temperatures are maintained between 42-44 degrees Celsius. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms are carpeted. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens are attractive. There is some garden seating available. Advised that outdoor tables have been ordered. There is currently no shade outside of the building (either natural or from umbrellas or shade cloths). Improvements are required in this area. There is wheelchair access to all areas. The gardens are all new with plantings and lawn areas now established.

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

ARC D15.3: The following equipment is available: pressure relieving mattresses, shower chairs, sling and standing hoists, heel protectors and mobility/handling aids.

Interviews with eight caregivers (four dementia, one rest home and three hospital) confirmed there is sufficient equipment.

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

E3.4.c: There is a safe and secure outside area that is easy to access off the dementia unit. The outside area for residents in the dementia unit is well designed and appropriate for residents who like to walk about.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The external areas are well maintained and gardens are attractive. There is some garden seating available. Advised that outdoor tables have been ordered. There is wheelchair access to all areas. The gardens are all new with plantings and lawn areas now established. There is a safe and secure outside area that is easy to access off the dementia unit. The outside area for residents in the dementia unit is well designed and appropriate for residents who like to walk about.

**Finding:**

There is currently no provision of shaded areas for residents to access when utilising the outside areas e.g. gardens and courtyards (either natural or from umbrellas or shade cloths).

**Corrective Action:**

Provide shaded areas for residents to access when utilising the outside areas.

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms in Ascot care home are single rooms - the majority with shared full ensuite. Two rooms in the dementia have their own full ensuite, eight rooms in the four rest home/hospital wings have their own full ensuite. There are sufficient toilets and showers for the resident population. There are an extra two communal toilets and one communal shower in the dementia unit. There is one communal toilet and one communal shower in each of the four wings. There is also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and privacy locks. Paper hand towel dispensers and flowing soap are available for use in all toilet areas. All 12 residents interviewed (eight rest home and four hospital) reported that their privacy is maintained at all times.

**Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

**Attainment and Risk:** FA

**Evidence:****Finding:****Corrective Action:**

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

### **Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

**Attainment and Risk:** FA

**Evidence:**

The resident rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Eight caregivers (four dementia, one rest home and three hospital) from across each area report that rooms have sufficient room to allow cares to take place. Twelve residents interviewed voiced their satisfaction for the size of their bedrooms.

### **Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is a large lounge/dining room in each of the four rest home/hospital wings, as well as a smaller sitting room at the end of each wing. In the main reception corridor there is a family room which residents and families can access. The dementia unit can be divided into two x 12 bed units with a lounge/dining room at the end of each wing. The dementia unit is currently run as one unit with all doors open to allow easy flow and for residents to safely wander. A nurse's station lies adjoining both lounges in the dementia unit and can be accessed from either lounge. All lounge/dining rooms in the facility are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and 12 residents interviewed report they can move around the facility and staff assist them if required.

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

### Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

**Attainment and Risk:** FA

**Evidence:**

There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Bupa has installed an Ozone laundry system at Ascot care home. Laundry services audits were completed in September 2014 (89%) with a corrective action plan in place. An environmental hygiene - cleaning audit was last completed in September 2014 and scored 98%. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste in each wing. These are locked when unattended. Twelve residents and 16 family interviewed confirmed that the facility was kept clean.

### Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)**

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

**Attainment and Risk:** FA

**Evidence:**

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety and fire drills occurred in at the new staff orientation day held prior to occupancy in November 2014. Fire drills are held six monthly – last conducted on 4 September 2014. Emergency management training is held as part of staff orientation.

There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kits are readily accessible as well as a daily updated resident register. There is an approved evacuation plan (11 November 2013) and each wing has emergency management flip charts.

The facility is well prepared for civil emergencies and has emergency lighting, gas cooking, gas heating in the rest home/hospital resident lounges and a gas BBQ. A store of emergency water is kept – each wing has a 500 litre water tank which is refreshed and available for emergency supply. Emergency food supplies sufficient for at least three days are available. Extra blankets are also available.

Hoists have battery backup and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and personal protective equipment (PPE) are kept.

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

The call bell system is available in all areas and indicator panels in each area. During the tour of the facility, residents were observed to have easy access to the call bells.

Satisfaction survey conducted in August 2014 identified that residents and families were overall, very happy with the security. The afternoon and night registered nurses complete a security check list each day.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The facility has overhead/ceiling heating, heat pumps and wall mounted heaters which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored monthly.

All 12 residents and 16 relatives interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident's rooms.

### Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint policy (251) states the organisations philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however we acknowledge that there may be occasions when a resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated'. There is a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint co-ordinators at each of the Bupa facilities (1 July 2014 minutes sighted). There are also monthly restraint meetings at the facility where all residents using restraint or enablers are reviewed (19 August 2014 and 17 September 2014 minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.

The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has no residents using enablers. The service currently has two residents (one in the hospital using a lap belt and one in the dementia unit using a fall out chair) assessed as using a restraint. A register for each restraint is completed that includes a monthly evaluation.

The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Only staff that have completed a restraint competency assessment are permitted to apply restraints. All staff restraint competency assessments have been completed at the time of audit.

There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisational level and at a service level. Interview with the restraint co-ordinator and review of her signed job description identifies her understanding of the role.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety.

On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Two restraint files were reviewed (one hospital and one dementia). Both residents' files included completed assessments that considered those listed in 2.2.2.1 (a) - (h).

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

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (table tops, bed rails, lap belts, and fall out chairs).

The restraint co-ordinator is a registered nurse (from the dementia unit) and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.

Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint co-ordinator. Restraint use is reviewed monthly during the facility restraint meetings and also as part of the monthly restraint reviews.

The restraint co-ordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

The resident's file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed in one hospital and one dementia residents' files with restraint identified the restraint/risks/observations and monitoring requirements. Monitoring charts were reviewed as being completed. Restraint use is reviewed through the monthly assessment evaluation, monthly restraint meetings and six-monthly multi-disciplinary meetings and includes family/whanau input.

A restraint register is in place providing an auditable record of restraint use. This has been completed for the two residents requiring restraint.

**Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)**

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)**

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of two of two files of residents using restraints identified that evaluations are up-to-date in one file (rest home) and have reviewed (but not limited to); whether the desired outcome was achieved, whether the restraint was the least restrictive option and the impact of the use of restraint (one resident has been on restraint less than one month). Restraint is evaluated on a formal basis monthly at the facility restraint meeting and six monthly by the regional restraint team. Evaluation timeframes are predetermined by risk levels.

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

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

(a) Future options to avoid the use of restraint;

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. The Restraint Co-ordinator stated; reduction of restraint is an on-going target at the facility as they constantly working on the reduction of restraint within the facility.

The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. Restraint education has been provided in August 2014 and a restraint audit has been completed in April 2014 with 96.4% compliance.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control co-ordinator (sighted) and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system.

The facility has access to professional advice within the organisation and has developed close links with the GP's, community laboratory, the infection control and public health departments at the local DHB. There are monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff.

Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The regional committees and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level.

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

### **Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control committee is a small group including; (but not limited to) the clinical manager (IPC co-ordinator), a caregiver, a house keeper, laundry representative and the care home manager. The facility also has access to an infection control nurse, public health, community laboratory, GP's and expertise within the organisation.

#### **Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)**

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

**Attainment and Risk:** FA

**Evidence:**

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.

There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.

Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.

External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control co-ordinator, the infection control committee and expertise from the governing body. Policies reviewed September 2014.

### **Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)**

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 3.4: Education (HDS(IPC)S.2008:3.4)**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control co-ordinator is responsible for coordinating/providing education and training to staff. The IC co-ordinator is the clinical manager and has been in the role since April 2014 with previous experience in the IC co-ordinators role for three years at another aged care service. The IC co-ordinator has completed the Infection prevention and control course on line (MOH) in March 2014. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, and Bug Control for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was held in June 2014 (18 attended). All training is mandated by Bupa and evaluated by staff who attend. Records of the evaluations were sighted.

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

**Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)**

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)**

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)**

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

**Attainment and Risk:** FA

**Evidence:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. Data sighted for August 2014 included an increase in urinary tract infections (UTI)s in the dementia unit with a corrective action plan initiated and interventions updated in the residents care plans. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators.

Internal infection control audits also assist the service in evaluating infection control needs. An audit in September 2014 has 99% compliance with improvements required regarding staff wearing nail polish and staff wearing engagement rings. This is to be addressed at the next staff meeting. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

The service has identified an outbreak of respiratory infections in the dementia unit September 2014. Four residents were noted with respiratory symptoms on 8 September 2014 which increased to eight residents 12 September 2014. All residents have been seen by the GP, treated with antibiotics and are fully recovered. All staff and visitors have been fully informed with appropriate signage at the facility entrance. The service is currently analysing the data for evaluation (link 1.2.4.2)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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