

Bupa Care Services NZ Limited - Erin Park Rest Home & Hospital

Current Status: 28 May 2014

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

General overview

Bupa Erin Park rest home and hospital provides care for up to 115 residents at rest home, hospital and residential disability level of care. Occupancy on the day of audit was 112 residents; including 62 hospital residents, 48 rest home residents and eight residents under residential disability contracts.

Erin Park has an experienced aged care facility manager (non-clinical) that has been in the role for the last six years. The manager is supported by a Clinical Manager (RN) with considerable experience in gerontology who has been with the service for eight years. The service has addressed the two shortfalls identified at the previous audit around resuscitation plans and integrated records.

This audit identified improvements required around the documentation of care plan interventions and enablers. Residents and relatives interviewed spoke positively about the care and support provided at Erin Park.

Audit Summary as at 28 May 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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 28 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 28 May 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 28 May 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 low risk.
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Safe and Appropriate Environment as at 28 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 28 May 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Infection Prevention and Control as at 28 May 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Bupa Care Services NZ Limited
Certificate name:	Bupa Care Services NZ Limited - Erin Park Rest Home & Hospital
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Erin Park Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical
Dates of audit:	Start date: 28 May 2014 End date: 29 May 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	111

Audit Team

Lead Auditor	XXXXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXXXX	Total hours on site	24	Total hours off site	7
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXX			Hours	2

Sample Totals

Total audit hours on site	36	Total audit hours off site	15	Total audit hours	51
Number of residents interviewed	7	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	6	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	100	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Thursday, 10 July 2014

Executive Summary of Audit

General Overview

Bupa Erin Park rest home and hospital provides care for up to 115 residents at rest home, hospital and residential disability level of care. Occupancy on the day of audit was 112 residents; including 62 hospital residents, 48 rest home residents (including one respite resident) and eight residents under residential disability contracts.

Erin Park has an experienced aged care facility manager (non-clinical) that has been in the role for the last six years. The manager is supported by a Clinical Manager, registered nurse (RN) with considerable experience in gerontology who has been with the service for eight years.

The service has addressed the two shortfalls identified at the previous audit around resuscitation plans and integrated records.

This audit identified improvements required around the documentation of care plan interventions and enablers.

Residents and relatives interviewed spoke positively about the care and support provided at Erin Park.

Outcome 1.1: Consumer Rights

Residents and relatives are kept well informed at an organisational and facility level. Relatives interviewed confirmed they were well informed of incidents/accidents and changes of health status. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility, there is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed. The service has links with Tainui local Iwi and has a Kuia staff member and links to cultural and spiritual advisors.

Outcome 1.2: Organisational Management

Erin Park Rest Home and Hospital continues to implement the Bupa quality and risk management system to evidence continued improvements. Quality and risk performance is reported across the facility meetings, and also to the organisation's management.

Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Erin Park Rest Home and Hospital is benchmarked in two of these (rest home and hospital). 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. Corrective action plans are established when necessary if incidents are above the benchmark.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and the requirements.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. The Bupa wage analysis schedule (WAS) is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide.

Outcome 1.3: Continuum of Service Delivery

The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A

registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around the documentation of interventions to reflect the resident's current needs. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed three monthly by the general practitioner. The activities programme is facilitated by an activities coordinator and activity assistant. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meets the recreational preferences and abilities of the consumers groups. All food and baking is done on site. All residents' nutritional needs are identified and documented, choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans.

Outcome 1.4: Safe and Appropriate Environment

The building holds a current warrant of fitness. Electrical equipment is checked annually. All medical equipment is calibrated and all hoists and electric beds are checked and serviced. Hot water temperatures are monitored monthly and are at 45 degrees and below.

Outcome 2: Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. There is an improvement required around enabler documentation. The service currently has three residents in the hospital assessed as using a restraint (three bedrails). A register for each restraint is completed that includes a three-monthly evaluation. The restraint standards are being implemented and implementation is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings.

Outcome 3: Infection Prevention and Control

The infection control (IC) programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	2	0	0	0
Criteria	0	41	0	2	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	32
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2 008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2 008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The following shortfalls have been identified around interventions for (1) Rest Home: a) there is no documentation around behaviour monitoring for a rest home resident, b) two behaviour monitoring forms do not specify the reason for the monitoring for two rest home residents; c) the care summary and long term care plan did not identify the high falls risk for a frequent faller (corrected on day of audit) for one rest home resident; (ii) Hospital files: d) one sacral pressure area is not identified in the care plan. There are no pressure area management interventions documented in the care plan for a hospital resident; e) there are no documented interventions for one hospital resident with unintentional weight loss, f) there is no documentation of weight loss in the care plan of a palliative care resident.	Ensure care plans reflect the resident's current needs.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(RMS P)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMS P)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	The service has three residents in the hospital that have fixed lap belts attached to their wheelchairs. These have not been identified as enablers and there has been no assessment, consent or documentation in the residents care plan.	Ensure that all residents using lap belts as enablers have assessments, consents and documentation in the care plan.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Accident/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 and two registered nurses 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 May 2014 identified that 10 of 10 incident forms demonstrated that family were notified.

D16.4b: All seven (three rest home and four hospital) 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 one rest home and one hospital resident currently representatives from Erin Park. Meeting minutes were sighted at Erin Park Rest Home and Hospital. 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 is a number of staff who is able to assist with interpreting for care delivery. One of the goals at Erin Park for 2014 is to develop a communication book for residents unable to speak English or have difficulty communicating. A policy on contact with media is also available. 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. 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. The information pack is available in large print if requested 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: The previous finding around resuscitation treatment plans has been addressed. Seven of seven files evidenced all resuscitation plans are appropriately signed.

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

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

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

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: <p>The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and also 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.</p> <p>Discussion with five rest home and two hospital residents and seven relatives (four hospital and three rest home) confirmed they were provided with information on complaints and complaints forms.</p> <p>2014 complaints were reviewed which included seven written complaints and four verbal complaints. All were well documented including investigation, follow-up letter and resolution.</p>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>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. Erin Park Rest Home and Hospital has set specific quality goals for 2014 including (but not limited to); a) To reduce falls through managing action that puts residents at risk of falling, b) To eliminate bruising and skin tears through staff handling of residents, c) To improve job satisfaction through "butterfly moments", and d) to develop a communication book for residents unable to speak English or have difficulty communicating. Strategies are in place for each goal and progress is reported quarterly with</p>

January to March progress report documented.

Bupa Erin Park Rest Home and Hospital provides care for up to 115 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 111 residents; including 62 hospital residents, 48 rest home residents and one rest home respite resident. The service has six dual service beds. There are eight residents under residential disability (physical) contracts.

The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Erin Park Rest Home and Hospital is part of the Northern (1) Bupa region which currently includes eight facilities. The managers in the region teleconference weekly. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Erin Park Rest Home and Hospital 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 (sighted at Erin Park Rest Home and Hospital). 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 Jan 10.

Erin Park Rest Home and Hospital has an experienced aged care facility manager that has been in the role for the last six years. The manager is supported by a Clinical Manager (RN) that has been in the role for eight years and worked for 20 years in aged care prior to her position at Erin Park. There are job descriptions for both positions that include responsibilities and accountabilities. 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.

The manager and clinical manager has maintained at least eight hours annually of professional development activities related to managing a hospital

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>Erin Park Rest Home and Hospital continues to implement the Bupa quality and risk management system to evidence continued improvements. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team.</p> <p>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. A number of core clinical practices also have education packages for staff, which are based on their policies. These are implemented at Erin Park Rest Home and Hospital. A Bupa 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.</p> <p>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/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.</p> <p>Key components of the quality management system link to the monthly unit meetings and three monthly general staff meeting at Erin Park Rest Home and Hospital and the three monthly quality committee. The monthly FM/CM meeting also includes a thorough review of incidents/complaints etc. Weekly reports by facility manager to Bupa operations manager and month quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and</p>

organisation.

There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home/hospital and staff incidents/accidents. The service has linked the complaints process with its quality management system. Weekly and monthly manager reports include complaints. Infection control is included in the quality meeting. 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 is an agenda item at the quality committee. Minutes include discussion of quality data collected, trends and corrective actions identified are followed through to improve on clinical indicators. The service collects data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. The service has implemented a number of corrective actions. An action plan was established around improving meals and labelling of resident clothes (as a result of survey feedback). A resident satisfaction survey was last completed February 2014 with 85% overall satisfied. Action plans were established as a result of the feedback and discussed with residents. A corrective action plan was established around activities with the need for increased entertainers, increased van outings and to investigate opportunities for residents to participate in community groups. This is to reviewed in June 2014

The service also implements 'quality indicator - corrective action plans' (QI-CAP) where incidents/infections are above the benchmark including increased falls and bruising, January – April 2014. Tool box talks and practical demonstrations to staff to reduce skin tears and bruising from staff handling of residents were evidenced as part of a (QI-CAP). During the audit staff were observed attending a tool box talk on minimising bruising. Audit summaries and action plans are completed where a noncompliance is identified. Falls prevention is one of the four annual quality goals at Erin Park

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. There is a health and safety officer at Erin Park and a committee of four other representatives. All health and safety representatives have completed training in levels 1, 2 and three.

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 but not limited to; 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, sensor mats, providing new residents with the booklet on reducing falls, encouraging residents to join the falls prevention programme, walkers to be in reach of residents and staff to remain in the bedroom when at risk residents are toileted. Falls prevention is one of the four annual quality goals at Erin Park

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA
Evidence: 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)". One incident form was sighted for a category one incident following a resident fall with injury and immediate transfer to the emergency department with appropriate management, neurological observations, documentation and follow up. Incident forms reviewed for March 2014 (ten forms) identified clinical follow up by a registered nurse/clinical manager and monitoring (such as neuro obs) having been undertaken when indicated. Opportunities for improvement are documented on the incident form by clinical manager. 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. Quality indicator- corrective action plans are established when they were above the benchmark, including (but not limited to); falls and bruising January-April 2014. Discussions with service management, overall confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Register of registered nurse (RN) and enrolled nurse (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).</p> <p>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 (e.g. caregivers two weeks, RN four weeks), during this period, they do not carry a clinical load.</p> <p>Staff interviewed (five caregivers, two enrolled nurses and two registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files were requested for view (one registered nurse, one enrolled nurse, two caregivers, one chef and one activity coordinator). All staff files had evidence of orientation, appraisals, compulsory training sessions and staff competencies are up to date.</p> <p>Interviews with the manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national level two certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures). Currently Erin Park has 95% of caregivers enrolled or qualified and 70% have NZQA level three in support of the older person.</p> <p>There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. delirium, dementia. Bupa is the first aged care provider to have a council approved PDRP. The nursing</p>

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. One RN at Erin Park has commenced this.

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.

RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, restraint, syringe drivers, wound management, and quality and risk

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. There are registered nurses across 24/7 including two on night shift. The facility manager is supported by clinical manager who

is a registered nurse The clinical manager acts as the facility manager when the facility manager is on leave or a relief manager is implemented. The clinical manager and the two unit managers share the on call service. Interviews with five caregivers that work across the facility identified that staffing levels were overall good.

Interviews with seven residents (five from the rest home and two from the hospital) and seven relatives (three from the rest home and four from the hospital) stated overall that staffing was adequate.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: FA
Evidence: Seven of seven resident records sampled evidence integration of resident records. This is an improvement since the previous audit.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>Erin Park rest home and hospital level of care for up to 115 residents. On the day of audit there are 64 hospital level of care residents with two residents in dual service beds within the rest home unit. There is one designated district health board respite bed. There is a registered nurse in the rest home unit and the hospital unit 24/7. Enrolled nurses (EN) are also employed in the rest home unit. A registered nurse (RN) undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. This is evident in all seven files sampled (three rest home, three hospital and one residential disability). Within three weeks, the long term care plan is developed in seven of seven files sampled.</p> <p>In seven of seven files sampled the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission by the contracted general practitioner (GP) in seven files sampled and six monthly multi-disciplinary reviews (MDR) and meeting minutes completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person such as the physiotherapist. The MDR checklist identifies the family member who has attended the MDR review.</p> <p>Seven residents interviewed (two hospital and five rest home) stated that they and their family are involved in planning their care plan and at evaluation. Resident files included family/whanau contact records, which are completed and up to date in the seven resident files sampled (three rest home, three hospital and one YPD). Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.</p> <p>Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There are written handover sheets that cover each shift and identify mobility status for each resident and any significant events that have occurred such as falls, infections and changes to health. Progress notes are written on each shift, dated, timed, and signed with designation. RN entries are also identified with a “nursing “stamp. Seven files (three rest home, three hospital and one YPD) identified integration of allied health and a team approach is evident in the seven files.</p> <p>The GP interviewed spoke positively about the service and describes very effective communication processes. The GP interviewed reports they are contacted promptly of any change to a resident’s condition.</p>

In seven of seven files (three rest home three hospital, and one Young Person with Disabilities (YPD), an activities coordinator has completed activity assessments and the activities sections of the “My day, my way” long term care plans.

Tracer Methodology residential disability- ID:

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

Tracer methodology rest home: .

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

Tracer methodology hospital resident:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.5: 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: Not audited

Evidence:

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: Not audited

Evidence:

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

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

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

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

Attainment and Risk: PA Low
<p>Evidence:</p> <p>The registered nurses complete residents' care plans. A care summary is also readily for caregivers to access. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The five caregivers interviewed (four hospital and one rest home) and two ENs (one rest home and one hospital) stated that they have all the equipment referred to in care plans and necessary to provide care, including hoists, wheel-on scales, chair scales (calibrated December 2013), wheelchairs, tilting shower chairs, electric beds, sensor mats, mobility aids, continence supplies, dressing supplies and any miscellaneous items.</p> <p>Registered nurses stated that when something that is needed is not available, management provide this within a timely manner. Seven residents interviewed (two hospital and five rest home) and seven families interviewed (four hospital and three rest home) are complimentary of care received at the facility.</p> <p>The care being provided is consistent with the needs of residents; this is evidenced by discussions with caregivers, registered nurses, enrolled nurses, and the clinical manager.</p> <p>Dressing supplies are available and a treatment room is stocked for use. 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.</p> <p>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.</p> <p>Continence management in-services and wound management in-service have been provided.</p> <p>Wound assessment and wound management plans are in place for four residents in the rest home (two wounds, one foot ulcer and one pressure area toe). There are wound assessment and management plans in place for seven chronic wounds, two pressure areas and five skin tears in the hospital. There is a specific management plan in place for a resident with a chronic pilonidal sinus on admission. There is an improvement required around the documentation and intervention of pressure area management.</p> <p>The clinical manager and registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.</p> <p>There is a physiotherapist contracted for 10 hours per week who undertakes an initial physiotherapy assessment and transfer plans for all residents. The physiotherapist follows up residents post falls and is involved in the facility falls prevention programme and multidisciplinary reviews. RNs complete a physical assessment and post fall investigation for residents who fall</p> <p>The RN completes risk tool assessments on admission including continence, falls, pressure area, nutritional assessments, pain assessments, cultural assessment and dependency rating.</p> <p>Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional record, two hourly turning chart, lowa pain monitoring tool and behaviour monitoring.</p>

There is an improvement required around the documentation of interventions to reflect the resident's current needs. Residents interviewed confirm their needs are being met.

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

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

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

Attainment and Risk: PA Low

Evidence:

The RN completes risk tool assessments on admission including continence, falls, pressure area, nutritional assessments, pain assessments, cultural assessment and dependency rating.

Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional record, two hourly turning chart, lowa pain monitoring tool and behaviour monitoring. Residents interviewed confirm their needs are being met.

Finding:

The following shortfalls have been identified around interventions for (1) Rest Home: a) there is no documentation around behaviour monitoring for a rest home resident, b) two behaviour monitoring forms do not specify the reason for the monitoring for two rest home residents; c) the care summary and long term care plan did not identify the high falls risk for a frequent faller (corrected on day of audit) for one rest home resident; (ii) Hospital files: d) one sacral pressure area is not identified in the care plan. There are no pressure area management interventions documented in the care plan for a hospital resident; e) there are no documented interventions for one hospital resident with unintentional weight loss, f) there is no documentation of weight loss in the care plan of a palliative care resident.

Corrective Action:

Ensure care plans reflect the resident's current needs.

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an activity coordinator who has been with the service for 17 months, holds a level 4 NZQA in aged care and is currently renewing her first aid certificate. She is employed for 37.5 hours a week and is supported by an activity assistant who has been with the service for six months and is employed for 27.5 hours per week. The activity team have access to Bupa diversional therapy (DT) team at head office and attend the regional DT/activities regional study days with training and education including guest speakers.

The activity programme is implemented Monday to Friday between the hours of 9am to 4pm. The service is actively seeking to appoint a physio assistant who will coordinate an exercise and walking programme which will ensure there is a range of activities in all three lounges simultaneously. There are separate rest home and hospital programmes with activities that meet the needs and preferences of the two consumer groups however many activities are integrated such as entertainment as

observed on the day of audit. Programmes are displayed and delivered to residents rooms. Variations to the programme are made known to the residents. Residents may choose to participate in the group programme. One on one time is spent with residents who are unable to or choose not to participate in the group programme. There is a full activity programme which includes (but not limited to): indoor bowls, crosswords, walking groups, bingo, quizzes, movies, karaoke, balloon tennis, mini golf and exercises. There are regular visiting entertainers and community groups such as church groups/singers, school choirs, RSA monthly, pet therapy and school groups. There is catholic church service weekly on Fridays. Rest home and hospital residents have the opportunity to go on outings in the service wheelchair access van. A caregiver accompanies the activity person on outings. An outings register is maintained. The family/resident completes a Map of Life on admission which includes previous hobbies, community links, family, and interests. The individual activity plan in all resident files sampled (three rest home, three hospital and one YPD) identify activities and community links that reflect the residents normal patterns of life. Seven resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review. Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting and resident satisfaction surveys.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Support plans are reviewed and evaluated by the registered nurse at least six monthly in five (two rest home, two hospital and one YPD) of seven files sampled. One rest home resident and one hospital resident are new to the service. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person such as the physiotherapist. The MDR checklist identifies the family member who has attended the MDR review. There is at least a one- three monthly review by the medical practitioner. There are short-term care plans available to focus on acute and short-term issues (link 1.3.6.1). Short term care plans in place sighted are for chest and wound infections and evidence regular evaluations.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Medications are managed appropriately in line with accepted guidelines. The medications are stored in a locked trolley in the treatment rooms (rest home and hospital). Controlled drugs are stored in a locked safe in the treatment rooms and only the registered nurses have access to controlled drugs and two people (one being an RN) must sign for the checking and administration of controlled drugs. Registered nurses and enrolled nurses administer medications and all have completed annual medication competencies and attended annual education sessions. ENs and RNs complete competencies for insulin and controlled drugs. RNs complete additional competencies for subcutaneous fluids and syringe driver.

The service uses robotic roll system and PRN are dispensed in individual medication bottles. The RN on night shift checks all regular robotic rolls against the medication chart on delivery. PRN medications and pharmacy stock are checked for expiry dates regularly. Controlled drugs are checked weekly. A pharmacy audit is completed six monthly last March 2014. GP standing orders are current. An antibiotic stock is kept in the hospital unit for GP prescribing after hours. All eye drops in use are dated on opening. Medication fridge temperatures are completed daily with evidence of corrective action for temperatures outside of the acceptable range.

There are currently no residents self-administering. All PRN medication administered are dated and timed. Signing sheets correspond to instructions on the medication chart. There are no gaps on the signing sheet. There are two signatures on the signing sheet for controlled drugs.

Fourteen medication profiles sampled are legible, up to date and reviewed at least three monthly by the G.P. There are photos (dated) and allergy status documented on all 14 medication charts sampled. 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 e) replacement roll f) short course medication.

There is an antipsychotic medication plan for residents with dementia on antipsychotic medication. There are instructions in the medication room for the management of hypoglycaemia and hyperglycaemia.

Fourteen medication charts reviewed (six rest home, six hospital and two YPD) identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: 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 1.3.12.3 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site. Resident likes and dislikes are known and alternative choices offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Special diets are noted on the kitchen notice board, which can be viewed only by kitchen staff. Special diets being catered for include normal, soft diets and pureed diets. Lip plates are provided to promote and maintain independence with meals. Meals are served from bain maries to the residents in the rest home and hospital dining rooms.

The kitchen manager receives written notification for any dietary changes or requirements and this information is transferred to the kitchen whiteboard for quick reference. The service employs a kitchen manager Monday to Friday and a weekend cook. Both are supported by a second cook on duty and two kitchen hands daily.

The service has a large workable kitchen that contains a walk-in pantry, freezer, fridges, chiller, gas hobs, combi-oven, bain marie, microwave and commercial baking equipment. There is rotation of stock of up to three times a week. Hot food temperatures are monitored on all meals daily (records sighted). Fridges and freezers have temperatures monitored daily. Chilled inward goods are temperature checked prior to storage. Daily air temperatures are recorded.

The fire extinguisher and fire blanket have been checked within the last year. All chemicals are locked away when the kitchen is unattended.

Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number of audits completed including; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit..

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

The kitchen manager attends regular teleconferences and an annual cook's conference with other Bupa cooks.

Staff have been trained in safe food handling and chemical safety.

Seven residents (two hospital and five rest home) interviewed comment positively on the meals provided

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a current building of fitness that expires 16 May 2015. The Bupa comprehensive maintenance schedule includes reactive maintenance and repairs and a planned maintenance programme which is up to date. Electrical equipment is tested and tagged. Medical equipment is calibrated and all hoists and electric beds are checked and serviced. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Residents are observed moving freely around the areas with mobility aids where required. The external areas are well maintained with shaded seating area. There is wheelchair access to all areas. Hot water temperatures are monitored monthly and are at 45 degrees and below.

The following equipment is available, hoists, wheel-on scales, chair scales (calibrated December 2013), wheelchairs, tilting shower chairs, electric beds, sensor mats, mobility aids and pressure relieving mattresses. Interviews with five caregivers, two enrolled nurses and two RNs confirmed there was adequate equipment.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: PA Low

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 coordinators at each of the Bupa facilities. Restraint/enablers are also discussed in the quality meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what 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 one resident on the register with an enabler in the form of bedrails. The file reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service has three residents in the hospital that have fixed lap belts attached to their wheel chairs. These have not been identified as enablers and there has been no assessment, consent or documentation in the residents care plan. This is an area that requires improvement.

The service currently has three residents in the hospital assessed as using a restraint (three bedrails). A register for each restraint is completed that includes a three-monthly evaluation.

The restraint standards are being implemented and implementation is reviewed at the service through internal audits, quality meeting and at an organisational level through regional restraint meetings

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: PA Low

Evidence:

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 one resident on the register with an enabler in the form of bedrails.

Finding:

The service has three residents in the hospital that have fixed lap belts attached to their wheelchairs. These have not been identified as enablers and there has been no assessment, consent or documentation in the residents care plan.

Corrective Action:

Ensure that all residents using lap belts as enablers have assessments, consents and documentation in the care plan.

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

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN unit manager) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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