

Bupa Care Services NZ Limited - Harbourview Rest Home & Hospital

Current Status: 18 September 2014

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

General overview

Bupa Harborview provides care for up to 58 residents across two service levels; rest home care (26 beds) and hospital – geriatric and medical services (32 beds). On the day of audit there were 29 hospital residents and 25 rest home residents. The facility manager (enrolled nurse) who has been in this role since July 2011 is supported by a clinical manager who has been in the role for the last six months. The management team is supported by the operations manager (RN) who visits at least weekly.

Four of eight shortfalls identified at the previous audit have been addressed around integration of resident records, human resource documentation, wound care and medication documentation. Shortfalls that continue to require improvement include corrective action planning, aspects of care planning/evaluation and staffing. This audit identified an improvement required around collection of quality data.

Audit Summary as at 18 September 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 18 September 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 18 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 medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 18 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 18 September 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 18 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 18 September 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 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Bupa Care Services NZ Limited
Certificate name:	Bupa Care Services NZ Limited - Harbourview Rest Home & Hospital
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Harbourview Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 September 2014 End date: 19 September 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	54

Audit Team

Lead Auditor	XXXXXX	Hours on site	13	Hours off site	5
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	2

Sample Totals

Total audit hours on site	13	Total audit hours off site	7	Total audit hours	20
Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	13	Total number of staff (headcount)	63	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	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 Friday, 24 October 2014

Executive Summary of Audit

General Overview

Bupa Harborview provides care for up to 58 residents across two service levels (rest home-26 beds and hospital - geriatric/medical- 32 beds). On the day of audit there were 29 hospital residents and 25 rest home residents. The facility manager (enrolled nurse) has been in this role since July 2011. He is supported by a clinical manager who has been in the role for the last six months. The management team is supported by the operations manager, registered nurse (RN) who visits at least weekly.

Four of eight shortfalls identified at the previous audit have been addressed around integration of resident records, human resource documentation, wound care and medication documentation. Shortfalls that continue to be a required improvement include corrective action planning, aspects of care planning/evaluation and staffing.

This audit identified an improvement required around collection of quality data.

Outcome 1.1: Consumer Rights

There is a policy to guide staff on the process to ensure full and frank open disclosure. Family interviews confirm that open disclosure principles are implemented and they were informed when their family member's health status changes. There is a complaints register that is up to date and includes relevant information regarding the complaint. The facility manager investigates all complaints and maintains the complaint register. Complaints are also further investigated by the operations manager as needed, and these are recorded in the complaints register. A record of all complaints per month is maintained, and these are reported to the Bupa head office for benchmarking with other Bupa facilities.

Outcome 1.2: Organisational Management

Bupa has robust quality and risk management systems and supports individual facilities in implementation of this system. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan and sets facility based specific quality goals. Harborview's 2014 quality goals are to reduce bruising in the hospital wing by 10% and decrease falls by 10%. Regular reporting on these goals including interventions and progress are documented.

A resident and family survey conducted in 2014 shows 89% satisfaction overall and food services at 92% satisfaction. There is an internal audit system that is implemented. Bupa provides benchmarking data back to Harborview via graphs and benchmarking reports. Improvements are required around closing out of corrective action plans relating to internal audits and collection of benchmarking data.

There is an annual staff training programme that is implemented, and this is based around policies and procedures. Records of staff attendance are maintained. There is a comprehensive health and safety programme. Hazard identification, assessment and management are maintained. There is an improvement required around reviewing staffing levels.

Outcome 1.3: Continuum of Service Delivery

The clinical manager and the registered nurses are responsible for each stage of service provision. There is evidence of resident/family participation in the development of the care plans. Long term care plans are reviewed at least six monthly. Risk assessments tools are available. Care plans demonstrate

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The internal audit schedule is implemented. The internal audits completed between March to August 2014 were reviewed, and audit summaries and action plans are completed where a noncompliance is identified. In two occasions, corrective action plan identified required actions but they were not documented as completed. Clinical file audit completed in May 2014 showed 89% compliance, and audit summary identified issues around non-compliance. The required corrective action plan was to re-audit in two months which was not completed. A care plan audit was completed in May 2014 and identified 90.5% compliance. Required action plan was identified as "one month follow up" but this has not been documented as actioned. Interview with the clinical manager also confirmed that required actions have not yet been implemented.	Ensure that required corrective action plans resulting from internal audit activity is implemented.	180
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		experienced service providers.				
HDS(C)S.2008	Criterion 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.	PA Moderate	<p>A review of the roster and interviews with staff and interview with two hospital residents indicate issues around staff's unavailability at times. Both days of the audit, staff were completing morning cares until 11.30 am. Staff interview confirmed that some residents have high needs and morning cares take longer and one resident requiring two person assistance and her cares takes up to an hour. Discussions with the facility manager confirmed he has requested additional staffing funding from the local DHB for one resident who requires more assistance for her personal cares. There is also another resident in the rest home that requires monitoring his whereabouts in 30 minute intervals. The resident was absconded from the facility in the first day of audit around 5 pm. The facility manager brought the resident back to the facility.</p> <p>Facility manager stated that staffing roster and duty schedules are reviewed since the previous audit ensuring each areas are managed separately. However due to resident's high dependency, staffing needs to reviewed again ensuring that residents needs are met timely.</p>	Ensure that staffing level is appropriate and meet resident's needs timely.	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			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	Two out of six files reviewed (one rest home and one hospital) showed that in both cases, residents were transferred from another Bupa facility, and initial admission and care plan documentation were not completed.	Ensure that initial assessment and short term care plans are completed within 24 hours of admission.	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Four files have completed care plan evaluations but in two files (two hospital), evaluations are not goal orientated and progress is not evaluated. Evaluations also included new interventions or repeat of current interventions. Such as changes in diet profile and new instructions are added rather evaluation of the current plan. There were also nothing documented in the care plan evaluations around behaviour monitoring and incident and accident reporting lead to any changes in the plan of care.	Ensure that care plan evaluations are goal orientated or indicate the degree of achievement towards meeting the desired outcomes	60

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:

Policies and procedures guide staff to the responsibility to notify family/NOK of any accident/incident that occurs. Resident files include family/whanau contact records and include notification of incident and accidents. Incident forms have a section to indicate if family/whanau has been informed (or not) of an accident, and all 14 incident forms (hospital /rest home) reviewed identified family were notified in all cases. Resident (three rest home and two hospital) and family (two from each area) interviews confirm that the facility manager and the clinical manager both have an open door policy.

Annual resident, relative and food surveys are completed that provide feedback on all areas of the service. Staff received training around communication in May 2014.

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

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

D16.4b Four relatives interviewed (two from each areas) stated that they are always informed when their family members health status changes.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility manager investigates all complaints and maintains the complaint register. Complaints are also further investigated by the operations manager as needed and these are recorded in the complaints register. A record of all complaints per month is maintained and these are reported to the Bupa head office for benchmarking with other Bupa facilities.

The complaints register is up to date and includes relevant information regarding the complaint. Five complaints are reviewed and all include follow up letters. Resolution of complaints demonstrates that complaints are well managed, and actions and response are documented. One of these complaints is not resolved. The resident was most recently transferred to the local hospital and the family members requested a copy of resident notes from the service.

Discussion with five residents (three rest home and two hospital) and four relatives (two from each areas) confirmed they were provided with information on complaints.

D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa Harborview provides care for up to 58 residents across two service levels (rest home-26 beds and hospital -geriatric/medical- 32 beds). Under the medical component of their certificate there is currently one resident under age of 65. On the day of audit there were 29 hospital residents and 25 rest home resident. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan and sets facility based specific quality goals. Harborview's 2014 quality goals are to reduce bruising in the hospital wing by 10% and decrease falls by 10%. Regular reporting on their goals includes interventions and progress is documented. The facility manager (enrolled nurse) has been in this role since July 2011. He is supported by a clinical manager who has been in the role for the last six months. The clinical manager is an overseas trained registered nurse who had a similar role in another residential care facility in Wellington and previously had worked in the local hospice. He has seven years of experience in NZ. 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 (rest home), D17.4b (hospital), the facility 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Bupa has robust quality and risk management systems and supports individual facilities in implementation of this system.

Harborview 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. A master copy of all policies & procedures with associated clinical forms are maintained on site. These documents have been developed in line with current accepted best and/or evidenced based practice, and are reviewed regularly.

Key components of the quality management system link to the quality committee at Harborview that meets three monthly. Weekly reports by the facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organization.

There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home and hospital services, and staff incidents/accidents. An improvement is required around reporting and benchmarking.

Harbourview has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints.

The infection control (IC) is included in the quality meetings and staff meetings and the weekly reports from the facility manager cover infection control. Infection control is also included as part of benchmarking across the organization. There is an organisational regional IC committee. An improvement is required around documentation of surveillance data.

Health and safety meetings occur and health and safety is also an agenda item at the quality committee with feedback going to staff meetings. There is also falls focus group that meets bi monthly. Objective of this group is to evaluate falls for previous two months. Meeting minutes show discussions around methods of minimizing future falls and injuries.

There are also several other meetings ensuring that staff and residents are linked to every aspect of the quality programme. These include (but not limited to), residents meetings, registered nurse (RN) meetings, facility meetings and caregiver meetings.

Internal audit system is implemented and audit summaries include action plans. Bupa provides benchmarking data back to Harborview via graphs and benchmarking reports. An improvement is required around ensuring corrective actions identified as part of the internal audit activity is closed out on the corrective action plan. This was also a partial attainment in the previous audit.

Harborview annual quality goals include reduction of falls in the hospital wing by 10% and reduce bruising in the hospital wing by 10%. Progress related two these goals are documented.

A resident and family survey conducted in May 2014 shows 89% satisfaction. A survey evaluation has been conducted and results are communicated via graphs and reports. Following 2013 low score of food services survey (66%), this year Harborview achieved 92% satisfaction in food services. Family and resident interview also confirms satisfaction with food services and they all complimented the chef. Another improvement was also planned around access to community services and increased activities following previous consumer survey. Activities had 95% satisfaction in 2014.

There is an annual staff training program that is implemented and this is based around policies and procedures. Records of staff attendance are maintained.

D19.3: There is a comprehensive health and safety program. Hazard identification, assessment and management is maintained.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:**Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

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

Attainment and Risk: FA**Evidence:**

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the Operations Managers region is also provided for the Operations Managers which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Monthly summaries). Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Harbourview and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.

Finding:

The following gaps shortfalls were identified in relation to the implementation of the quality system; (i) Five of 19 incident forms reviewed for August had not been followed by the clinical manager and therefore was not included in benchmarking data. (ii) Two medication errors were not completed on incident forms and therefore not included in the benchmarking data. (iii) Infection control data is collected and documented in the infection surveillance form but outcome of infections is not documented. For example, in July, only one of the 19 infection surveillance data had outcome of infection control activities documented. June 2014 data (18 infections) did not have any outcome documented at all.

Corrective Action:

(i) Ensure that monthly quality data includes all reported incident and accidents. (ii) Ensure that all medication errors are documented as part of the incident reporting system. (iii) Ensure that outcome of surveillance activities are documented

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

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: PA Low

Evidence:

Harbourview continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There are three monthly facility meetings, residents meetings, quality meetings and monthly RN meetings. Meetings are held regularly and minutes are reviewed and corrective actions are developed and implemented following these meetings. Internal audit program is implemented. Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. Quality indicator analysis and corrective action plans policy is a guide for staff around corrective action plans. Corrective action plans remain an improvement required from previous audit.

Finding:

The internal audit schedule is implemented. The internal audits completed between March to August 2014 were reviewed, and audit summaries and action plans are completed where a noncompliance is identified. In two occasions, corrective action plan identified required actions but they were not documented as completed. Clinical file audit completed in May 2014 showed 89% compliance, and audit summary identified issues around non-compliance. The required corrective action plan was to re-audit in two months which was not completed. A care plan audit was completed in May 2014 and identified 90.5% compliance. Required action plan was identified as "one month follow up" but this has not been documented as actioned. Interview with the clinical manager also confirmed that required actions have not yet been implemented.

Corrective Action:

Ensure that required corrective action plans resulting from internal audit activity is implemented.

Timeframe (days): 180 (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 incident/accident forms re completed by all staff and initial follow up is completed by the RNs. Then investigations are completed by the clinical manager or the facility manager as required (link 1.2.3.6).

The staff interviews confirm understanding of their responsibilities on how and when to complete the incident/accident forms. Nineteen incident and accident forms from August and September 2014 are sighted as part of this surveillance audit. These incidences include three absconding incidences involving two different residents, one medication error, five falls, four bruises and one skin tear. Review of sample group of Incident and accidents reports shows that incidents and accidents are investigated and required interventions are put in place. For example, half an hourly monitoring is in place for one resident who was at high risk of absconding. The resident was referred to a specialist for medical review.

Falls prevention strategies are implemented such as the use of sensor mat, low bed, at least hourly rounds by the staff, review of footwear, and medical review.

Discussions with the management confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. In an interview, the facility manager stated that the coroner and the MOH- Health Cert team has been notified regarding an unexpected death in 2014. An infectious outbreak occurred in March 2014 and the local DHB and the public health authorities were notified.

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incident. 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)". A monthly Cat One summary is sent out to care homes.

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 organization's benchmarking program and this is used for comparative purposes. However, this audit identified that not all incident and accident data is entered in to the benchmarking data (link 1.2.3.6).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Register of RN and EN practicing 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). Eight files are reviewed (the clinical manager, one registered nurse, five caregivers, and a cook). All files had completed orientation programme records. Five staff had recent performance appraisals and three staff were recently employed and there were not due for performance appraisals yet. These two areas were identified as requiring improvement in the certification audit and the service has completed the required corrective actions. 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 are sighted in reviewed files. There is a competency register that is maintained by the clinical manager. This is an improvement since the previous audit. There is an annual education schedule that is being implemented. There is an RN/EN training day provided through Bupa that covers clinical aspects of care - e.g. Wound management. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training. Discussion with staff and management confirmed that a comprehensive in-service training program is in place that covers relevant aspects of care and support, and meets requirements. Bupa has the Nursing Council approved professional development recognition program (PDRP), and the clinical manager reported that there are no RNs with completed PDRP at Harborview yet and one RN is working on her portfolio currently.

D17.7d: RN competencies include; assessment tools, blood sugar levels/Insulin admin, control drug administration, moving & handling, nebulizer, oxygen administration, percutaneous endoscopic gastrostomy tube care/feeds, restraint, wound management, coronary pulmonary resuscitation, and T34 syringe driver.

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.

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

Criterion 1.2.7.4 (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.

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

Criterion 1.2.7.5 (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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p>

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. There is a registered nurse across 24/7. Previous audit identified an improvement required around review of staffing for both rest home and hospital. Review of the roster and interview with two RNs and one EN confirmed that rest home and the hospital roster is separate and duty allocations are reviewed. However this audit showed that staffing levels requires further review therefore required corrective action has not been fully addressed.

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: PA Moderate

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. There is a registered nurse across 24/7. Previous audit identified an improvement required around review of staffing for both rest home and hospital. Review of the roster and interview with two RNs and one EN confirmed that rest home and the hospital roster is separate and duty allocations are reviewed.

Staffing roster is as follows:

Facility Manager Mon – Fri

Clinical Manager Mon - Fri

Hospital (29 residents)

AM

RN 0645 - 1500

2x caregivers 0700 - 1500

1x caregiver 0700 - 1330

3x caregivers 0700 - 1400

PM

RN 1445 - 2300

1x caregiver 1500 - 2300

2x caregiver 1500 - 2200

1x caregiver 1700 - 2300

1x caregiver 1400- 2100

Nocte

RN 2245 - 0700

1x caregiver 2300 - 0700

Rest home (25 residents)

AM

1 x enrolled nurse 0645 – 1500 (EN works 4 on 2 off = 2 morning and 2 afternoons) where the EN is not on that shift this is filled by a senior CG.

1x caregiver 0700 - 1500

2x caregiver 0700 - 1300

PM

1x enrolled nurse 1445 - 2300 (see above)

1x caregiver 1500 - 2300

1x caregiver 1500 - 2130

1x caregiver 1645 - 2100

Nocte

1x caregiver 2300 - 0700.

The facility manager interviewed stated that staffing levels are regularly reviewed and changes have been made however currently there are residents with high acuity.

Finding:

A review of the roster and interviews with staff and interview with two hospital residents indicate issues around staff's unavailability at times. Both days of the audit, staff were completing morning cares until 11.30 am. Staff interview confirmed that some residents have high needs and morning cares take longer and one resident requiring two person assistance and her cares takes up to an hour. Discussions with the facility manager confirmed he has requested additional staffing funding from the local DHB for one resident who requires more assistance for her personal cares. There is also another resident in the rest home that requires monitoring his whereabouts in 30 minute intervals. The resident was absconded from the facility in the first day of audit around 5 pm. The facility manager brought the resident back to the facility.

Facility manager stated that staffing roster and duty schedules are reviewed since the previous audit ensuring each areas are managed separately. However due to resident's high dependency, staffing needs to reviewed again ensuring that residents needs are met timely.

Corrective Action:

Ensure that staffing level is appropriate and meet resident's needs timely.

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

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

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

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

Attainment and Risk: FA

Evidence:

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses' station in a secured room. Records can be accessed only by authorised staff and professionals.

Four of six files reviewed showed that 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. Two files did not evidence initial assessment and care planning documents. See CAR- 1.3.3.3.

Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing.

Resident documentation is integrated. Short term care plans are integrated in to the residents file. Wound assessment and management forms are still kept in the separate folder but the residents file includes information about wound management plans and links to wound folder. An interview with two RNs showed that two folders are linked and all related staff know where to obtain necessary information. Therefore, required corrective actions from the previous audit around integration of resident's information system has been addressed.

D7.: Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name.

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

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

Attainment and Risk: FA

Evidence:**Finding:**

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.3: 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:

Assessment, planning, evaluation, review and exit are undertaken by a registered nurse with input from the GP, health professionals, caregivers, residents and the family members. Two out of six files reviewed (one rest home and one hospital) showed that in both cases, residents were transferred from another Bupa facility, and initial admission and care plan documentation were not completed. Activity assessments and the activities sections care plans have been completed.

Three residents (two rest home and one hospital) interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Two residents (one rest home and one hospital) interviewed stated that they do not recall the care plan specifically having been discussed but they stated that they are able to make any suggestions and maintain freedom of choice as much as possible.

Resident's files included family contact records which were completed in all resident files sampled. All family members (two from each area) interviewed confirmed on-going consultation in all areas of the service delivery.

D16.5e: All resident files (three from each area) 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 where this is the case. More frequent GP review was evidenced as occurring on review of resident's files with acute conditions. Harbourview has a variety of processes to ensure a co-ordinated service.

A range of assessment tools were completed in resident files on admission and completed at least six monthly. A nutritional assessment was evidenced completed for a resident requiring dietary supplements prescribed by GP.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Six files reviewed identified that integration of allied health and a team approach is evident.

Tracer x1 Rest home

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

Tracer methodology x2

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:

D16.2, 3, 4: The six files reviewed (three from each area) identified that in two rest home and two hospital files had an initial assessment completed within 24 hours of admission and care plans were developed within three weeks. There is documented evidence that care plans were reviewed by a RN and amended when current health changes. All four care plans evidenced evaluations completed at least six monthly. Two files were recent admission and were not due.

D16.5e: Six 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.

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 d) cultural assessment, e) skin assessment, and f) nutritional assessment. This was evident in four out of six files.

Finding:

Two out of six files reviewed (one rest home and one hospital) showed that in both cases, residents were transferred from another Bupa facility, and initial admission and care plan documentation were not completed.

Corrective Action:

Ensure that initial assessment and short term care plans are completed within 24 hours of admission.

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 1.3.5: 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:

Four out of six files reviewed showed that care plans are individualised and included support and intervention required. (link CAR -1.3.3.3). The progress notes also reflective of care plan interventions and short term care needs of residents.

All six resident files reviewed identified that family were involved. 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. Notes by GP and allied health professionals, significant events, communication with families are included in the sample group of resident's files.

Two resident's files (hospital) reviewed included residents with ESBL and MRSA. Both care plans included interventions around standard precautions. Staff interviewed confirm knowledge around this. On the both days of audit staff are observed using standard precautions and these are placed next to the door of the resident's room. The RN interviewed stated that she monitors staff compliance on use of standard precautions. Therefore required corrective action around minimisation of risk of infections have been addressed. Review of wound management log and file review of two residents with wounds confirmed that wound documentation is complete, long term, and short term care plans include interventions around wound care management. One resident with sacral pressure had risk assessment completed, and specialist input obtained and required pressure relieving equipment is provided. Therefore, required corrective action from the previous audit have been completed.

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:

Harborview provides services for residents requiring rest home and hospital level care. The care being provided is consistent with the needs of residents, this is evidenced through interviews with four caregivers, four families (two from each areas), five residents (three rest home and two hospital), two registered nurses, and the clinical manager.

Although two residents file out of six did not have initial assessment and the care plan, progress notes are reflective of residents needs and staff interviewed also are knowledgeable around residents' nursing needs.

D18.3 and 4: Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management and pressure injury prevention in-service have been provided April 14 and February 14 respectively. A wound management initial assessment and wound management plan were in place and there are 14 wounds. Currently one resident had a pressure ulcer and review of the resident file reflects management of the pressure ulcer and the RN described specialist input and GP monitoring in to her wound. Two RNs, the clinical manager and the facility manager interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. The facility has RN cover 24/7 and has a comprehensive 'in service' education programme. The GP interviewed stated that the clinical care is good at Harborview and the GP receives appropriate and timely referrals from the RNs. The GP monitors XXXXX levels of one resident requiring XXXX treatment, and she faxes the new treatment plan to the nursing team as needed. Family interview (two from each area) also confirms satisfaction with care provided to their loved ones. Two hospital residents interviewed commented on lack of staffing at times but stated that staff are very caring and the home is very good. Three rest home residents are also happy with the care provided by the service.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The activities staff (three) provides activities in the hospital and rest home. On the day of audit residents in both areas were observed being actively involved with a variety of activities. The program is developed monthly and displayed around the facility. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review/evaluated. A record of individual residents activities are kept and reviewed regularly. 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 the hospital and rest home setting and include networking within the community. Residents interviewed (two hospital, three rest home) stated they are happy with the variety of activities, outings and entertainment. Consumer satisfaction survey 2014 showed 95% satisfaction with the activities provided. Activities internal audit results (July 2014) showed 86% compliance and required corrective actions are completed.

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: PA Moderate

Evidence:

Four out of six residents' files sampled demonstrate that the care plans are reviewed and updated as resident's health status changes. Two files did not have current care plans. (link CAR 1.3.3.3). Wound management plans are current, residents weights are monitored and weight loss and gains are documented in the care plans. Resident's nutritional profiles are up to date and the chef interviewed is aware of resident's nutritional needs. Residents' files evidence referral letters to specialists and other health professionals. Four caregivers interviewed are all knowledgeable around residents current care needs. There is an evidence of consultation with GP when this occurs and the GP or the clinical manager sends a referral to seek specialist service provider assistance or refers back to needs assessors. The resident and family member is involved in this process. Referrals to varying health providers are evident in the resident files. Two registered nurses (RN)s and one enrolled nurse (EN) interviewed confirm that processes are implemented and acute changes in resident's health status have been addressed.

Four files have completed care plan evaluations but in two files (two hospital), evaluations are not goal orientated and progress is not evaluated. Evaluations also included new interventions or repeat of current interventions. Such as changes in diet profile and new instructions are added rather evaluation of the current plan. There were also nothing documented in the care plan evaluations around behaviour monitoring and incident and accident reporting lead to any changes in the plan of care. Previous shortfalls around evaluations remain an area for improvement.

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: PA Moderate

Evidence:

Evaluation of resident care plans is undertaken six monthly by a RN and input is sought from the resident, family, GP, and caregiver. Staff record and report any changes they notice in resident's behaviour or wellness. Care plans include achievable set of goals and residents are assisted toward achieving these goals or positive outcomes. Six files reviewed and two of them are not due. Two out of four files have care plan evaluations reflect desired outcome or progress towards identified goals.

Finding:

Four files have completed care plan evaluations but in two files (two hospital), evaluations are not goal orientated and progress is not evaluated. Evaluations also included new interventions or repeat of current interventions. Such as changes in diet profile and new instructions are added rather evaluation of the current plan. There were also nothing documented in the care plan evaluations around behaviour monitoring and incident and accident reporting lead to any changes in the plan of care.

Corrective Action:

Ensure that care plan evaluations are goal orientated or indicate the degree of achievement towards meeting the desired outcomes

Timeframe (days): 60 (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 locked trolleys in the locked room for the rest home and the hospital. 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. RNs, ENs and medicine competent caregivers administer medications and medication competencies are maintained annually.

The service uses two weekly robotic packs, delivered monthly. All PRN medications are kept in the blister packs. One medication was directly administered from a bottle (Warfarin) due to ongoing changes in dosage. Ongoing Medication charts have photo ID's.

Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures.

Medication management training was last provided in February 2014. Medication audit was last undertaken in September 2014 and showed 94.1% compliance and required corrective actions were completed.

There are currently no resident self-administering in the rest home and the hospital. One resident was prescribed warfarin for anticoagulant therapy and dosage was adjusted by the GP after the XXXX test. (International Normalized Ratio). Review of signing sheets shows compliance with the prescription.

Review of 13 medication files revealed that medication profiles are legible, up to date and reviewed at least three monthly by the GP. Signing sheets correspond to instructions on the medication chart except on two occasions where medication error reporting was not completed. See CAR 1.2.3.1.

The controlled drug register is well kept and aligns with legislative requirements. Stock control is maintained and expired medications are returned to the pharmacy. PRN medication and non-packed medication are administered as prescribed. A glucagon injection is kept in the fridge and has a current use date. Stoke medication is maintained and all other drugs have name stickers on them. RNs interviewed stated that all unused drugs are returned to the pharmacy. Therefore, required corrective actions from the previous audit around medication management system have been addressed.

Residents/relatives interviewed stated they are kept informed of any changes to medications.

D16.5.e.i.2; 13 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: 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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a six weeks rotational summer and winter menu. The menu is audited by a registered dietitian and the same menu is used nationally in all Bupa services.

D19.2: Staff have been trained in safe food handling. All of the kitchen team at Harbourview have completed food safety certs.

The service has a large workable kitchen located downstairs of the building and food are transferred to rest home and the hospital in bain marie using lift.

Kitchen fridge, food and freezer temperatures are monitored and documented daily. Food storage and temperature monitoring audits are completed and required corrective actions are maintained. Resident annual satisfaction survey is completed in 2014 which includes food.

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 and special diets are being catered for includes gluten free diet, dairy free diet, normal diet, soft diet, pureed diet and diabetic diet. Resident's likes and dislikes are also accommodated.

Consumer satisfaction survey result showed 66% satisfaction around food services. Discussion with the facility manager confirmed that to address this low level of satisfaction, food services were fully evaluated and a new chef was employed in March 2014. The chef serves the meals in the rest home and always in touch with the residents ensuring that meals are enjoyed by all and alternative options are provided. Consumer survey 2014 shows 92% satisfaction in food services and residents interviewed stated that food services are of high standard.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The building holds a current warrant of fitness which expires on 30/6/15.

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.)*

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Currently the rest home has no enablers or restraint. There are three hospital residents on the register with an enabler in the form of bedrails. There are five residents in the hospital who have been assessed as requiring restraint, which are bedrails and two of these residents are also using T belts.

A register for the restraint and enablers is maintained and residents' file include completed consent forms and a comprehensive restraint and enabler assessment.

Staff completed restraint competencies and were received training in February 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The clinical manager is the infection control coordinator who 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 coordinator. Infection control data is reported at the quality meetings.

The surveillance of infection data assists in evaluating compliance with infection control practices. Staff received IC training in January 2014 and following an outbreak in April 2014. An infectious outbreak (norovirus) occurred in 28 March, and 24 residents and 11 staff members were affected. The public health authorities were notified and a de briefing occurred after the outbreak. The facility has adequate signage at the entrance asking visitors not to enter if they have contacted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print.

IC data is benchmarked against the other Bupa facilities, and Harbourview shows low infection rates on skin and wound infections and high infection rates on respiratory and eye infections. Staff interviewed are knowledgeable around areas of high infection rates and stated that infection control surveillance activities are regularly discussed during handovers. There is close liaison with the GP's that advise and provide feedback /information to the service. June, July and August IC surveillance data are reviewed. In June, there were 11 infections in Hospital and seven infections in the rest home. All these infections are treated with antibiotic but outcomes were not documented. In July,

there were 12 infections in the hospital and seven in the rest home. All these infections are also treated with antibiotics but only one had outcome noted as resolved. The August data also had similar pattern and outcomes of infections were not documented. (link CAR 1.2.3.6).

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.)*