

Bupa Care Services NZ Limited - Gardenview Rest Home

Current Status: 8 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

Gardenview Rest Home is part of the Bupa group and is certified to provide dementia care for up to 41 residents and on the day of audit there were 39 residents. Gardenview's facility manager and clinical nurse manager are well qualified for their roles. Staff turnover remains low. There are well developed systems that are structured to provide appropriate quality care for residents.

Implementation is supported through the Bupa quality and risk management programme that is individualised to Gardenview. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service has addressed the three shortfalls from the certification audit around corrective action planning, incident reporting and monitoring and follow up after incidents. This audit identified further improvements are required around incident reporting, interventions, aspects of medication management and restraint.

Audit Summary as at 8 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 8 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 8 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 8 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 8 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 8 September 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 8 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 - Gardenview Rest Home
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Gardenview Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 September 2014 End date: 8 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:	39
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Audit Team

Lead Auditor	XXXXXXXX	Hours on site	8	Hours off site	6
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Other Auditors	XXXXXXXX	Total hours on site	8	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	1

Sample Totals

Total audit hours on site	16	Total audit hours off site	13	Total audit hours	29
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Number of residents interviewed	0	Number of staff interviewed	8	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	47	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	0

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 Wednesday, 1 October 2014

Executive Summary of Audit

General Overview

Gardenview Rest Home is part of the Bupa group and is certified to provide dementia care for up to 41 residents and on the day of audit there were 39 residents. Gardenview's facility manager and clinical nurse manager are well qualified for their roles. Staff turnover remains low. There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Gardenview. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service has addressed the three shortfalls from the certification audit around corrective action planning, incident reporting and monitoring and follow up following incidents.

This audit identified further improvements around incident reporting, interventions, aspects of medication management and restraint.

Outcome 1.1: Consumer Rights

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

Outcome 1.2: Organisational Management

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

Outcome 1.3: Continuum of Service Delivery

The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A clinical manager/registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input as applicable. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. The previous audit finding around timely provision of medical follow-up has been addressed. This audit identifies and improvement around documentation and implementation of interventions to reflect the residents current needs.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Five files were traced and in two files the following was noted: two instances of bruising and one of a skin tear being reported in progress notes, at the time of audit an accompanying incident form could not be found. (one incident form was found during the audit). Noting appropriate action taken was also reported in the notes in all cases, based on this the risk is considered to be low.	Reported incidents are managed in the prescribed manner.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	(i) There is no evidence of GP notification for one resident with an episode of XXXXX. The resident has a history of hypertension and on aspirin. There is a short term care plan in place and staff have been completing blood pressure monitoring. (ii) There is no food and fluid monitoring/interventions for one resident who continues to lose weight. (iii) Reported episodes of challenging behaviours for one resident has	Ensure care plans reflect the resident's current needs and interventions are identified and implemented.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				not been documented on a behaviour chart. The same resident has reported breakthrough pain. There is no lowa pain monitoring tool in place. The resident has weight loss and the short term care plan in place (evaluated September 2014) documents continuation of the nutritional record and fortnightly weights. There is no evidence of fortnightly weights or continuation of the nutritional record since 24 August 2014.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	1) There is no GP signature for controlled drugs (Fentanyl patches) on one medication chart. 2) There is no GP signature for one discontinued medication. 3) The controlled drugs prescribed have not been reviewed since prescribed in April 2014.	1) and 2) Ensure medication prescribed and discontinued is signed by the GP. 3) Ensure medication charts are reviewed three monthly.	30
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	During the tour three external doors are found to be keypad locked restricting the freedom of residents to the safe external walking paths and gardens.	Eliminate the practice of environmental restraint.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Accident/incident, category ones (i.e., major resident incidents), complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is a specific policy to guide staff on the process to ensure full and frank open disclosure is available. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. 10 incident forms reviewed across August identified that family were notified following a resident incident on eight of the forms. The other two forms stated family did not wish to be notified of minor incidents. Incident/accident forms are audited as part of the internal auditing system and a criterion is identified around "incident forms" informing family. The audit was completed in April (2014) and confirmed family notification.

A residents/relatives association was initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician.

At an organisational level, a residents/relatives association provides a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician. Newsletters were in place at Gardenview. Interpreter policy and contact details of interpreters. A list of Language Lines and Government Agencies is available.

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

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

D16.4b Five relatives stated that they are informed when their family members health status changes.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

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

Attainment and Risk: FA
Evidence: The complaints procedure (065) states 'the facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint management record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. The

complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with five relatives confirm they were provided with information on complaints. Complaint forms were visible for residents/relatives in various places around the facility. There are three complaints recorded across 2014 and there is well documented investigation, follow up and resolution. There are a number of compliments recorded.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa Gardenview provides care for up to 41 dementia residents across two wings. One of these beds is dedicated for respite and on the day of audit was vacant. There were 39 residents on the day of audit.

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. Gardenview 2014 quality goals include: reducing medication errors by 20% and improving the gardens. Progress is reported through the quality meetings and followed through in each of the staff/other meetings.

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

Gardenview is part of the central Bupa region which includes eight facilities. The managers in the region teleconference monthly and meet six monthly. A forum is held every six months (with national conference) including all the Bupa managers. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care including - knowledgeable staff / meaningful activities / comfortable environment. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans have been implemented. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care.

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

The service is managed by an experienced registered nurse who has been the facility manager at Gardenview for approximately a year, and prior to this was the clinical nurse manager at the facility. She has been at Gardenview for six years. The clinical nurse manager is a registered nurse who was appointed to the role March 2013. Support is also provided by the operations manager who visits at least once each month. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical nurse managers attend annual organisational forums and regional forums six monthly.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Gardenview is implementing the Bupa quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team. The service has policies and implemented systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule. Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation. The release is notified by email to all clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the quality meetings at Gardenview who meet monthly. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical nurse manager that break down the data collected across the unit and staff incidents/accidents. The service has linked the complaints/compliments process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints/compliments. The Gardenview infection control committee meet two monthly and the weekly reports from the facility manager cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. Health and safety committee meets two monthly and is also an agenda item at the quality committee with feedback going to staff meetings.

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

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

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

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

D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has an H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for with two objectives that include a reduction of moving and handling incidents by 50%. On-going review of objectives for Gardenview in H&S meeting minutes.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats. Gardenview also have a Falls Focus Group that meet bimonthly with a particular focus on reducing the falls rate in the unit.

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.

<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>
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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.

<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>
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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.

<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.)*

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the

status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting category one incidents. The completed form is forwarded to the quality and risk team as soon as possible (definitely within 24 hours of the event), even if an investigation is on-going. Ten incident forms were reviewed across August. All forms were completed appropriately, including clinical manager review and facility manager sign out. There was evidence of neurological observations being completed and wound plans/STCP's were being implemented appropriately, education resulting from an incident/trend is seen to have been completed (eg. challenging behaviour). This is an improvement from the previous audit. Five files were traced and there are instances where incidents reported in progress notes do not have an accompanying incident form. This is a required improvement.

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

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Refer evidence 3.5.7 re norovirus outbreak.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Incidents are reported using the appropriate form and all reviewed are seen to have been completed appropriately including actions taken. Residents are reviewed at the time of incident by a registered nurse and appropriate actions are seen to have been taken. Incident reports are reviewed by the clinical manager and included on monthly data sheets. Four files were traced.

Finding:

Five files were traced and in two files the following was noted: two instances of bruising and one of a skin tear being reported in progress notes, at the time of audit an accompanying incident form could not be found. (one incident form was found during the audit). Noting appropriate action taken was also reported in the notes in all cases, based on this the risk is considered to be low.

Corrective Action:

Reported incidents are managed in the prescribed manner.

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

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

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

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

Attainment and Risk: FA

Evidence:

Register of practising certificates is maintained and website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / links). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (clinical nurse manager – who is also the infection control coordinator, an enrolled nurse, three caregivers, cook, activities) and all had personal file checklists. Performance appraisals are current in files reviewed.

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

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

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

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

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

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

E4.5f: 19 (of 25) caregivers have completed the required dementia standards and six caregivers are in the process of completing.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. There is a first aid trained member of staff on every shift. Interview with two caregivers inform the senior staff are supportive and approachable. Interviews with staff, residents and relatives inform there are sufficient staff to meet the care needs of the residents. Staffing is as follows:

AM & PM: 5x caregivers 0700-1500 (various times), ND: 3x caregivers.

The facility manager (RN) works Monday through Friday and the clinical nurse manager (RN) works Saturday through Wednesday.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Bupa Gardenview provides dementia level of care for up to 41 residents. The clinical manager (CM)/ registered nurse (RN) undertakes the initial nursing assessment and risk assessments on admission, with the initial support plan completed within 24-48 hours of admission. This is evident in all five resident files sampled. Within three weeks, the long term care plan is developed as sighted in all five resident files sampled. In all five files sampled the initial admission assessment, care plan summary and long term care plan is completed and signed off by the clinical manager/registered nurse. Medical assessments are completed on admission within 48 hours by the contracted general practitioner (GP) in the five files sampled. All residents assessed for dementia care have been approved by the support links and psychogeriatrician and a letter of mental incapacity is on the residents files sampled. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. Currently the GP is on leave and locum cover has been provided. The CM (interviewed) states there is good communication and good medical support provided 24/7. The GP has input into the multidisciplinary reviews (MDT), carries out three monthly reviews. Families are invited to the GP visits and reviews. There is evidence of involvement in resident files from the geriatrician and psychogeriatric service who are readily available by referral/phone. This is an improvement since the previous audit.

A contracted physiotherapist is shared between the two Bupa facilities in the town. A podiatrist visits regularly.

Five family members interviewed stated that they are involved in their relative's care planning process and at evaluation. Resident files included family/whanau contact records, which are completed and up to date in the five resident files sampled. There is evidence of family notification for changes in health status, infections, incidents/accidents, GP visits, care plan reviews, weight loss, allied health visits and challenging behaviours.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a written handover book that cover each shift and identify mobility status for each resident and any significant events that have occurred such as falls, infections and changes to health. Progress notes are written on each shift, dated, timed, and signed with designation. Clinical manager entries are identified with a "clinical nurse review" stamp. Five files sampled identified integration of allied health and a team approach. In the five files sampled an activities coordinator has completed initial activity assessments and the activities sections of the "My day, my way" long term care plans. Each resident has a "map of life" in their file completed in consultation with the resident/family as appropriate.

Tracer methodology; Rest Home resident

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The CM/RN completes residents' care plans. A care summary is readily available for caregivers. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the CM/RN initiates a review and if required, GP or specialist consultation. There is documented evidence (family contact sheet) of family notification when a resident health status changes. The two caregivers and one enrolled nurse interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a standing/sling hoist (checked October 2013), weigh scales, sensor mats, mobility aids, continence supplies, dressing and medical supplies.

Registered nurses stated that when something that is needed is not available, management provide this within a timely manner. Five family members interviewed are very positive about the delivery of care and services provided at the facility.

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

Initial wound assessment and wound management plans with ongoing evaluations at the instructed frequency are in place for four skin tears, minor lesion, chronic lesions, one haematoma and one wound over granulation. There are two pressure areas (one grade 1 buttocks and one grade 2 ankle). The chronic pressure area (buttock) is linked

to the long term care plan and a short term care plan is in place for the pressure area ankle reported September 2014. The GP is aware as per the medical notes. There is evidence of wound nurse involvement in chronic wounds. Pressure area resources identified in the care plans of the two residents with pressure injuries include position changes (turning charts), spenco mattresses and pressure bootees. Additional resources can be accessed from the Bupa hospital facility in the town.

The RN completes risk tool assessments on admission including continence, falls, transfer plans, pressure area risk, nutritional assessments, pain assessments, cultural assessment and dependency rating. All five files include a specific dementia needs plan.

Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, lowa pain monitoring tool and behaviour monitoring chart. There is an improvement required around the documentation and implementation of interventions to reflect the resident's current needs in regards to weight management, behaviour monitoring and GP follow-up of clinical episodes.

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 residents' care plans. A care summary is readily available for caregivers.

The RN completes risk tool assessments on admission including continence, falls, transfer plans, pressure area risk, nutritional assessments, pain assessments, cultural assessment and dependency rating. Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, lowa pain monitoring tool and behaviour monitoring chart.

Finding:

(i) There is no evidence of GP notification for one resident with an episode of epistaxis. The resident has a history of hypertension and on aspirin. There is a short term care plan in place and staff have been completing blood pressure monitoring. (ii) There is no food and fluid monitoring/interventions for one resident who continues to lose weight. (iii) Reported episodes of challenging behaviours for one resident has not been documented on a behaviour chart. The same resident has reported breakthrough pain. There is no lowa pain monitoring tool in place. The resident has weight loss and the short term care plan in place (evaluated September 2014) documents continuation of the nutritional record and fortnightly weights. There is no evidence of fortnightly weights or continuation of the nutritional record since 24 August 2014.

Corrective Action:

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

Timeframe (days): 60 (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 co-ordinator and activity assistant employed on a four on four off roster that covers a seven day week from 9.30 – 3.30pm. Both have completed core competencies (includes dementia course) and are supported by the company occupational therapist. The activity team attend the regional diversional therapy workshops. Both activity co-ordinators job have a current first aid certificate. As of 22 September the activity hours will change from midday to 6pm to provide activities and one on one activities for residents to best suit their individual recreational needs and preferences. The Bupa activity planner has set activities with the flexibility for the activity team to add dementia specific activities such as sensory, small group and community interactions focusing on past hobbies and everyday activities.

Activities include (but not limited to); exercise club, bowls, reminiscing, table games, word games, walks, arts and crafts, gardening, bread making, happy hour, pamper time, DVDs and storytelling time and bible reading. Each Monday there is a bacon and eggs breakfast. There is a ladies group. The men's group enjoy golf, pool and outings to the community men's shed. Residents have been involved in the wearable arts receiving two awards for costumes. Community visitors to the facility include Kapa Haka groups, school children (singing and dancing) and canine pets. Communion is held Sundays and there are other interdenominational church services are held on-site. Special events are celebrated and father's day was recently enjoyed with a visit from the vintage car club and drives. There are weekly outings with access to a shared Bupa wheelchair host van. Outings include scenic drives, Salvation companion group, Baptist church events and other community events. There is an open plan lounge and smaller quieter/family lounges in both units where small group or individual activities can take place. There is an open resource room available for residents and staff to access. Residents are free to wander safely between the units and attend activities.

The family/resident completes a Map of Life on admission which includes previous hobbies, community links, family, and interests. The individual activity plan in all resident files sampled identify activities and community links that reflect the resident's normal patterns of life. The activity plan (incorporated into the, my day, my way long term care plan is reviewed at the same time as the care plan at the multidisciplinary review. Individual activities participation registers are maintained. Residents have the opportunity to provide feedback on the activity programme through resident meetings and resident satisfaction surveys.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Care plans are reviewed and evaluated by the CM/RN at least six monthly in four of five resident files sampled. One dementia care resident has not been at the service long enough for a six monthly care plan evaluation. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident. Family members are invited to attend the MDT review and receive a copy of the care plan. There are three monthly reviews by the medical practitioner or earlier as required. 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 epistaxis vomiting, weight loss and skin tears. Regular evaluations are completed. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:**Corrective Action:****Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)**

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

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

Attainment and Risk: PA Moderate**Evidence:**

Medications are managed appropriately in line with accepted guidelines. The medications are stored in a locked trolley and locked medication in the Rimu unit and within the locked kitchenette areas of Pakeke unit. Registered nurses (clinical manager and facility manager), enrolled nurses (four) and caregivers who administer medications in the dementia units have completed annual medication competencies for oral medications, controlled drugs and insulin. All medication competent staff have completed annual medication education. The clinical manager has current syringe driver competency. There is a specimen signature

The service uses robotic roll system for regular medications and prn medications are dispensed in monthly blister packs. All pre-packaged medications are checked on delivery against the medication chart. Discrepancies are fed back to the supplying pharmacy. All regular and prn medications are prescribed for one to one use. There is a stock of standing orders and a current standing orders list. There is an antibiotic stock available for GP use after hours. Stock and expiry dates are checked weekly. Glucagon is available in the medication fridge and there is information on the management and treatment of hypoglycaemia displayed on the treatment room wall. The controlled drug safe is kept in the Rimu locked medication room. Controlled drugs are checked weekly. Currently there is one resident on a fentanyl patch. The pharmacy complete a six monthly pharmacy audit in October and June of each year (sighted in controlled drug register). There are no self-medicating residents. There is clinical equipment available (calibrated October 2013) including blood pressure and blood sugar level monitoring equipment, oxygen, suction and other pharmaceuticals and equipment. The medication fridge is monitored daily.

Ten resident medication signing sheets are sampled. Signing sheets correspond to instructions on the medication chart. There are no signing gaps. Controlled drugs are double signed on the signing sheet. The RN is contacted to authorise PRN medications. PRN medications are signed, dated and timed. The midday medication round observed in the Rimu unit confirmed compliance of medication administering procedures. There is an insulin injection plan in place for a resident on insulin. Iowa pain assessments are kept in the medication folder and utilised for the effectiveness of prn medications. There are medication management plans in place for the reduction of antipsychotic medications (as applicable). Alerts on medication charts include diabetic, crushed medications, duplicates names, sensitivity and allergy.

Ten medication charts sampled have photo identification and allergies/adverse reactions noted on the chart. There is an improvement required around GP prescribing.

D16.5.e.i.2; Nine of ten medication charts sampled identified that the GP had reviewed the resident medication chart three monthly (refer 1.3.12.1).

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

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

Attainment and Risk: PA Moderate

Evidence:

Ten medication charts sampled have photo identification and allergies/adverse reactions noted on the chart. There are medication management plans in place for the reduction of antipsychotic medications (as applicable). Alerts on medication charts include diabetic, crushed medications, duplicates names, sensitivity and allergy. D16.5.e.i.2; Nine of ten medication charts sampled identified that the GP had reviewed the resident medication chart three monthly.

Finding:

1) There is no GP signature for controlled drugs (Fentanyl patches) on one medication chart. 2) There is no GP signature for one discontinued medication. 3) The controlled drugs prescribed have not been reviewed since prescribed in April 2014.

Corrective Action:

1) and 2) Ensure medication prescribed and discontinued is signed by the GP. 3) Ensure medication charts are reviewed three monthly.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'. There is a monthly on-line forum for all Bupa facilities cooks. There is a cook, kitchen assistant and vegetable preparation person on duty each day. One kitchen staff member is the relieving cook. The national menus have been audited and approved by an external dietitian. Any changes to the menu are recorded. All baking and meals are cooked on-site. Resident likes and dislikes are known and alternative choices offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Dietary preferences, likes, dislikes and special diets (diabetic, moulieed, no red meat) are known and accommodated. The two staff interviewed could describe dietary interventions for weight loss. Meals are served from the kitchen to residents in the adjacent Rimu dining room and delivered by bain marie to the Pakeke kitchenette ready for serving. Lip plates and specialised utensils are provided to promote and maintain independence with meals. End cooked food temperatures are monitored on the main meal daily (records sighted). All foods are dated in the pantry, chiller, freezer and facility fridges. The service has a well equipped kitchen that contains a walk-in pantry, freezer, fridges, chillers, combi-oven, bain maries, microwave and commercial baking equipment. Fridge and freezer temperatures are monitored and recorded. The chiller and freezer have visual displays. All chemicals are stored safely. The main kitchen (Rimu) and kitchenette (Pakeke) are locked after hours. There are a number of audits completed including; a) kitchen audit, b) environment

kitchen, c) catering service survey, and d) food service audit. The cooks (interviewed) receive feedback on the food service and meals through resident meetings, kitchen meetings and quality/health and safety meetings. A communication book is used between food services and clinical staff. 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. Cleaning schedules are maintained. The maintenance person carries out cleaning of high walls and ceilings. The chemical provider completes service checks on the dishwasher. Staff have attended safe food handling NZQA unit standards and chemical safety.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a current building of fitness that expires 28 February 2015. The Bupa comprehensive 52 week 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 the hoist is checked and serviced. Residents are observed moving freely around the internal areas. Hot water temperatures in resident areas are monitored on a monthly rotating basis and are maintained at 45 degrees and below.

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

E3.4d; the lounge areas in both unit are designed so that space and seating arrangements provide for individual and group activities.

E3.3c; There is a safe and secure outside area (link 2.1.1).

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. The restraint co-ordinator is the facility manager.

The service actively promotes restraint minimisation and safe practice with the use of alternative strategies such as diversional therapy and sensor mats. The service does not have any enablers or restraints in use. The front door to the facility is keypad locked and this allows residents to wander internally between the two dementia units. There is an improvement required around environmental restraint within the unit.

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:

The front door to the facility is keypad locked and this allows residents to wander internally between the two dementia units.

Finding:

During the tour three external doors are found to be keypad locked restricting the freedom of residents to the safe external walking paths and gardens.

Corrective Action:

Eliminate the practice of environmental restraint.

Timeframe (days): 30 (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.

The service reports having had a norovirus outbreak June/July that affected 27 residents and 18 staff. These infections can be seen in the monthly data. The service was 'shut down' for three weeks. Appropriate notifications were reportedly made.

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.)*