# Bupa Care Services NZ Limited - Cedar Manor Rest Home & Hospital

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** Cedar Manor Rest Home & Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 24 November 2014 End date: 25 November 2014

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 89

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

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

## General overview of the audit

Cedar Manor Care Home is part of the Bupa group. The service is certified to provide rest home, hospital (including medical) and dementia level care for up to 92 residents. On the days of the audit there were 89 residents.

There are well-developed Bupa systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Cedar manor. 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 facility manager is currently supported by a relieving clinical manager (from another Bupa facility) who provides clinical oversite, peer support and advice.

This audit identified improvements required around aspects of staff documentation, care planning and medication documentation.

## Consumer rights

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

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

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Cedar Manor implements the Bupa quality and risk management system. Key components of the quality management system link to a number of meetings including quality meetings. A resident/relative satisfaction survey has been completed and there are regular resident/relative meetings. Quality data is collected and improvements are actioned. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Cedar Manor is benchmarked against hospital, rest home and dementia.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme for new staff with relevant information for safe work practice. There is an in-service training programme which is being delivered and covers relevant aspects of care and support. External training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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

There is a comprehensive admission package. A registered nurse assesses and reviews residents’ needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration. Changes to health status and interventions required are updated on the care plans to reflect the residents current health status. Resident files include notes by the GP and allied health professionals. Medication policies reflect legislative medicine requirements and guidelines. All staff responsible for administration of medicines completes education and medicine competencies. An activities programme is in place for all areas. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. All food and baking is done on site. All residents’ nutritional needs are identified and documented. Choices are available. Meals are well presented and a dietician has reviewed the Bupa menu plans. Nutritious snacks are always available.

## Safe and appropriate environment

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

Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. The majority of resident rooms are single; spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. There are two safe external areas for the dementia care residents that are freely accessible. There are adequate communal toilets and showers for the residents. Fixtures, fittings and flooring are appropriate. Cleaning and laundry services are well monitored through the internal monitoring system. Appropriate training, information and equipment for responding to emergencies have been provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The temperature of the facility is comfortable and constant – the facility has heat pumps and gas heating. Electrical equipment is checked annually. Hot water temperatures are monitored.

## Restraint minimisation and safe practice

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has six residents using enablers (bedrails). There are two residents assessed as using a restraint. . Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

## Infection prevention and control

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

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

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 47 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 98 | 0 | 3 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about ‘The Code’ at induction and as part of the in-service training programme. Interviews with five caregivers (across all three areas), one enrolled nurse and two registered nurses showed an understanding of the key principles of the code of rights. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has a policy in place for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents and signed outing consents on 11 of 11 resident files sampled (two rest home, one short stay, four hospitals, four dementia care). Resuscitation treatment plans and advance directives are appropriately signed in the 11 files reviewed.  Discussions with five caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussions with five registered nurses and one enrolled nurse identified that staff are familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.  D13.1 there were nine admission agreements and one short stay admission agreement sighted and all had been signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with caregivers, and registered nurses described how residents are informed about advocacy and support. Interviews with 10 residents confirmed that they are aware of their right to access advocacy.  D4.1d; Discussion with eight family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.  ARC D4.1e, Ten resident files reviewed included information on resident’s family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Visitors were observed coming and going during the audit. There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census.  D3.1.e: Interviews with ten residents confirmed that the activity staff help them access the community such as going shopping, attending appointments and visiting. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet.  There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented.  Discussion with 12 residents (eight rest home and four hospital) and 11 relatives confirmed they were provided with information on complaints and complaints forms.  2014 complaints received were reviewed and included four written complaints and three verbal complaints. All were well documented including investigation, follow up letter and resolution.  E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:  1. Minimising restraint.  2. Behaviour management.  3. Complaint policy |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. There are translators available for any resident who does not speak English.  On entry to the service, the care home manager or unit coordinators discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available at reception. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.  Interviews with 10 residents (three rest home and seven hospital) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints. Interviews with eight relatives (two rest home, two hospital and four dementia) confirmed they are informed of the code of rights. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | During the tour of the facility, respect for privacy and personal space was demonstrated. Resident files are held in the three locked nurses’ offices. Interview with caregivers could explain ways resident privacy is maintained. Interviews with 10 residents confirmed that privacy is ensured.  The September 2013 resident/relative satisfaction survey identified that 95% of residents stated privacy was either excellent or very good.  Residents and relatives interviewed were positive about the service in respect of considering and being responsive to meeting values and beliefs.  D4.1a: Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents.  Residents and family members confirmed that they have adequate rights to choose within the constraints of the service and that staff are obliging around choice.  Care plans reviewed identified specific individual likes and dislikes. There is a question around 'choice' in the resident/relative satisfaction survey.  A neglect and abuse policy (201) includes definitions and examples of abuse. Training provided March 2014.  D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Person centred care/individuality and independence training is provided to staff annually.  D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Personal belongings are documented and included in resident files. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | A3.2 There is a Maori health plan which includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)  D20.1i the Bupa Maori health policy was first developed in consultation with Kaumatua and is utilised throughout Bupa’s facilities. The CDHB Tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Local Iwi and contact details of Tangata whenua are identified.  There are two residents at Cedar Manor who identify as Maori. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process.  Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member’s stay/care. Cultural awareness and Maori health education was provided as part of the annual education programme November 2014. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete ' the map of life'. Discussions with eight relatives all identified that values and beliefs were considered. Discussions with 10 residents all stated they believed staff took into account their culture and values.  D3.1g: The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment, planning process and interviews with residents confirmed that cultural values and beliefs were considered and discussed during review of the care plan.  D4.1c: Ten resident’s files reviewed all included the resident’s social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. There is policy to guide staff practice: Gift, Gratitude’s and Benefits, Delegations of Authority. Registered nurses meeting (monthly) includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. Staff interviews described examples of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Cedar Manor is currently benchmarked in three areas – rest home, dementia and hospital. A quality improvement programme is implemented that includes performance monitoring. Graphs and data is provided to Cedar Manor staff on the noticeboard and corrective actions completed when trends are evident or areas are above the benchmark. Corrective action plans have been established and evaluated for effectiveness.  Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates.  ARC A2.2: Services are provided at Cedar Manor that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring.  ARC D1.3: all approved service standards are adhered to.  All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.  There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.  Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan (sighted with quality meeting minutes). Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation.  ARC D17.7c There are implemented competencies for caregivers, enrolled nurses and registered nurses.  Discussions with residents and relatives at Cedar Manor were overall positive about the care they receive. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.  Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for October and November 2014 identified that the sample of incident forms demonstrated that family were notified.  As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was completed in April 2014 with a result of 86%. The service followed this up with a corrective action that included toolbox talks to staff.  D16.4b: The eight relatives interviewed stated that they are always informed when their family members health status changes.  There is a Bupa residents/relatives association that provides a strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population.  D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry  D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  D11.3: The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan.  Bupa Cedar Manor provides rest home, hospital (including medical), and dementia specific care for up to 92 residents. On the days of the audit there were 90 residents: 27 rest home residents, 46 hospital level residents and 17 residents in the dementia unit.  The care home manager provides a documented weekly report to the Bupa regional operations manager. The operations manager visits regularly and completes a report to the general manager of Care Homes. Cedar Manor care home is part of the midlands Bupa region which currently includes 14 facilities. The managers in the region teleconference monthly. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Cedar Manor Care Home and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on-going progress to meeting their goals. A forum is held every six months (with national conference including all the Bupa managers).  The organisation has a Clinical Governance group. The committee meets two monthly. The committee reviews the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Feedback is provided to managers at forums and also to staff through newsletters. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly. Feedback is provided to each facility (sighted).  The facility manager is currently supported by a relieving clinical manager (from another Bupa facility) who provides support, peer support and advice. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. The service is currently advertising for a clinical manager.  ARC, D17.3di The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | A Bupa relieving care home manager is employed to cover temporary manager absences.  D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |
| 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. | FA | Cedar Manor Care Home has implemented a comprehensive quality and risk management system. Quality and risk performance is reported across the facility meetings, and also to the organisation's management team.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.  Key components of the quality management system link to the monthly quality meeting at Cedar Manor Care Home. Weekly reports by the care home manager to Bupa operations manager and quality indicator reports to Bupa quality manager provide a coordinated process between service level and organisation.  There are monthly accident/incident benchmarking reports that break down the resident data and staff incidents/accidents. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. There is a monthly infection control (IC) committee meeting.  Cedar Manor Care Home has implemented and reviewed their specific quality goals for 2014. Quality initiatives and corrective actions include (but not limited to) addressing falls rate, UTI’s and skin tears. Further quality improvements include (but not limited to) restructuring of staff for resident level of care.  The service collects data to support the implementation of corrective action plans. The internal audit schedule is being implemented. A resident and relative survey has been conducted recently.  D19.3: There is an H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has an H&S coordinator whom monitors staff accidents and incidents.  D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |
| 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. | FA | D19.3b and c; 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. Incident forms across the three areas were reviewed for October and November. Review of incident forms identified clinical follow up by a registered nurse/clinical manager and monitoring having been undertaken when indicated.  Discussions with service management, overall confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).  The service has implemented the Bupa orientation programme that provides new staff with relevant information for safe work practice. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development.  E4.5f: There are 13 caregivers working in the dementia unit. Eight have completed the required dementia standards, six are yet to start. All six have commenced employment in the past six months.  There is an annual education schedule that is being implemented. Staff have access to the Bupa tool box talks if and when required. Topics include infection control, falls prevention, food safety, and documentation, prevention of bruising, hand washing, and medication management. There is an RN training day provided through Bupa that covers clinical aspects of care. Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has approved and validated their PDRP for five years. Bupa takes over the responsibility for auditing their qualified nurses. Registered nurses at Cedar Manor have commenced their PDRP.  Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place.  A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files.  D17.7d: RN competencies include: assessment tools, BSLs/Insulin administration, controlled drug administration, moving and handling, nebuliser use, oxygen administration, restraint, wound management, PEG feeds, catheterisation, syringe driver use and sub-cut fluids. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The Bupa WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.  The care home manager and relieving clinical manager works fulltime Monday to Friday and is available on call after hours. The service has made a number of staffing and roster changes since previous audit.  There is a clinical lead position (RN) rostered in each of the three areas on morning and afternoon shift and two clinical leads across night shift.  Four caregivers, one enrolled nurse, two registered nurses, three unit coordinators, 10 residents and eight relatives confirmed that there are adequate levels of staff to meet the resident’s needs.  The service has introduced a new management structure to support the focus of more targeted leadership based on the floor. The new roles of Unit Coordinator and Housekeeping Manager have provided Cedar Manor with the opportunity to expand its support to the care and housekeeping teams, to enable and evaluate ‘smart’ goals. Their staffing levels are now higher in the areas where they are most required which the previous rigid roster did not adequately enable them to do, staff now work to care home assessed need level as opposed to geographic unit. Advised they continue to engage with the staff, residents and relatives for their feedback and have made necessary changes to systems, routines, shifts and methods as a result, they continue to improve and develop the model. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration. Improvements are required around documentation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has a well-developed information pack available for potential residents and an admission pack at entry. The information pack includes all relevant aspects of service and residents and family/whanau are provided with associated information such as the health and Disability Code of Rights and how to access advocacy. All potential admissions are screened to check they have a completed needs assessment and the service can provide the level of care. The three unit coordinators interviewed stated that there is good liaison and communication with the needs assessors, social worker, mental health team, GP’s and nurse practitioner.  There is an admission policy and an admission procedure.  E4. 1b: There is written information on the service philosophy and practices in the information pack.  D13.3: The admission agreement reviewed aligns with a)-k) of the ARC contract. The ten admission agreements sighted had all been signed within the required timeframe. One short stay admission agreement sighted had been signed on admission.  D14.1: Exclusions from the service are included in the admission agreement |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a policy that describes guidelines for death, discharge, transfer documentation and follow up. There is a transfer plan policy. A record is kept and a copy is kept on the resident’s file. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family/whanau notification of appointments and transfers. Eight relatives interviewed all stated that they were kept informed of the resident’s condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Medications are managed appropriately in line with accepted guidelines. Medication rooms/cupboards were checked across the three areas. Registered nurses in the hospital and senior caregivers in the rest home and dementia unit administer medications. All staff administering medications have completed an annual medication competency. Registered nurses also complete an annual syringe driver competency.  The service uses a robotic roll system for medications. All medications are checked on delivery against the medication chart and discrepancies are fed back to the supplying pharmacy. There is a small supply of hospital stock kept in a locked cupboard in the hospital medication room. All controlled drugs are checked weekly.  Self-medication residents are managed in line with accepted guidelines.  The 24 medication charts sampled included photo ID and allergies. The charts were clear and charted correctly. The signing sheets corresponded to the medication chart. The medication folder contained information on crushable medications and warfarin precautions. Antipsychotic medication management plans are in place for residents on these medications. As required medications signed as given in the dementia unit did not all include documented times of administration.  All medication charts sampled showed evidence of being reviewed by the GP three monthly |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All food is cooked on site in the main kitchen. The food is transported to the dining rooms in bain maries. The temperature of the food is checked before leaving the kitchen and again before being served. There is a cook on duty daily and she is supported by a morning and evening kitchen hand. All kitchen staff have just redone the food safety and hygiene standards this month (sighted). There is a kitchen manual and a cleaning schedule. Chemicals are stored in a locked cupboard and safety data sheets are available. Personal protective equipment is worn as appropriate. There are Bupa seasonal menus on a six weekly cycle and these have been approved by a consultant dietician. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are written up the kitchen whiteboard. Normal and moulied meals are provided. Fridge and freezer temperatures are recorded daily (sighted). Temperatures are recorded on all chilled and frozen food deliveries. All food in the chiller, fridges and freezers are dated. There is sufficient food stored to last for at least three days in an emergency. Stock is rotated by date. The kitchen is well equipped, clean and tidy. Food satisfaction surveys are done annually. Residents and relatives interviewed spoke positively about the food provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is an admission information policy. The service would record the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry is declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility uses the Bupa assessment booklets and person centred templates for all residents. The outcomes of risk assessments are reflected in the eleven care plans sampled (link 1.3.3.3) and interventions identify required support.  E4.2a Two files reviewed specifically for behaviour monitoring forms both evidenced behaviour assessment and monitoring |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Overall, care plans were comprehensive and demonstrate service integration and input from allied staff. Residents (three rest home and seven hospital) interviewed confirm care delivery and support by staff is consistent with their expectations. Residents and families interviewed stated that they were involved in the care planning and care plan evaluation process There is documented evidence on the care plan and in the family/whanau form of family involvement in care plan process.  The dementia files reviewed specifically for behaviour management included recognition of behaviours that are considered ‘normal’ and interventions for behaviour that challenge, including triggers and interventions for behaviour  D16.3k Short term care plans are in use for short term needs and changes in health. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | A care summary and the LTCP is readily available for caregivers. When a resident’ health status changes the registered nurse will review the resident and if required will ask the GP or nurse specialist for a consultation. There is documented evidence on the family/whanau form of family notification when a resident’s health status changes. All relatives interviewed stated that staff were approachable if they needed to discuss their relative’s health at any time.  Dressing supplies are available and sighted in the hospital treatment room and dressing trolleys are well stocked in each unit. Continence products are available and sighted and it is recorded in the care plan which product is needed and when. There is a comprehensive wound assessment with on-going evaluations and photos. There is GP and wound nurse specialist involvement in one on-going sacral pressure area and one abdominal burn (the latter now almost completely healed). Both are linked to the long term care plan. Short term care plans are in place. Monitoring forms are readily in use as directed by the registered nurses. Forms sighted included (but not limited to) monthly blood pressure and weight, pain monitoring, nutritional and food monitoring and behaviour monitoring. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are two activity co-ordinators who work a combined 60 hours Mon - Sat. A new activities assistant commences in the dementia unit December 2014. There is currently a temporary reliever there at present. The activity team attend Bupa training days and regional meetings/workshops held quarterly.  The weekly activity programme is displayed on noticeboards. There is a range of activities to meet most needs including entertainment, bingo bowls, and games. Group exercises are held for half an hour three times a week and the physiotherapist assists with these. There is a shop trolley which goes out weekly. Church services are held twice a month. The activity team state that the programme changes according to the mix of residents. Variations to the programme are notified to the residents.  The activity assistant has one on one time with residents who are unable or who choose not to participate in the programme. There are van outings four times a week. There is a separate programme for the residents in the dementia unit. There may be group or individual activities and these focuses particularly on cognitive, sensory and physical activities such as music, reminiscing, exercise, poetry and hand massage. There is memorabilia available to residents. On the day of audit activities were seen to be taking place and most residents were actively engaged.  Special occasions and birthdays are celebrated e.g. Anzac Day. All staff is encouraged to participate. 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 identifies activities and community links that reflect the resident’s normal patterns of life. Residents have the opportunity to feedback on the activity programme verbally or in resident satisfaction surveys Last survey had an 86% positive result with corrective action. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan evaluations are documented by the registered nurses (also link 1.3.3.3). Six monthly multi-disciplinary reviews (MDT) are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and if applicable then Physio. Family/whanau are invited to attend the MDT review and it is recorded which family member attends. There are short term care plans available to focus on acute and short term issues. These are evaluated regularly. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to podiatry, dietitian, and mental health services and wound care specialist.  D20.1 Discussions with unit coordinators and registered nurses identified that the service has access to GP’s, ambulance/emergency services, allied health, dietitians, continence and wound specialists and social workers |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is a waste and hazardous substance safety policy. Management of waste and hazardous substances is covered during orientation of new staff and chemical safety education is done annually. All chemicals are stored in locked cupboards. These cupboards are labelled hazardous substances. Safety data sheets and product wall charts are available. Approved sharps containers are used. These are easily identifiable. Gloves, aprons and goggles are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness. Reactive and preventative maintenance occurs. There is a maintenance person on staff. A 52 week planned maintenance programme is maintained. Outside contractors check and calibrate medical equipment annually and hoists six monthly. Hot water temperatures are monitored and maintained between 43-45 degrees Celsius. There are contractors for essential service available 24/7. Electrical testing and tagging has been completed August 2014.  The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are very wide in the new wing and adequate in the older wing. There are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained and easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas.  Cedar Manor has gone through an extensive refurbishment over the past year to various areas of the home, including all of ‘Craig’ unit bedrooms and the entire dining area. The hospital dining room and lounge and corridors have replaced furniture flooring and décor, in addition they have added an indoor / outdoor area to the lounge by creating a cover which is versatile and can be changed easily for all weathers. The main reception has been refreshed and redecorated for which they have received very positive feedback and the residents were observed to be enjoying sitting in the seated areas viewing information about Cedar Manor and any upcoming events televised. Advised that further areas are scheduled for 2015.  ARC D15.3 The staff interviewed stated that they have all the equipment referred to in care plans necessary to provide care.  E3.3e There are two safe and secure outside areas easily accessed by the residents in the dementia unit. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms in the refurbished wing have ensuites. In the older wing there are adequate numbers of communal toilets and shower rooms. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Shower rooms have privacy curtains. The residents interviewed reported that their privacy is maintained at all times. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms in the refurbished wing are single and spacious. In the older wing the rooms are single but there are two larger rooms which can be shared by husband and wife. In the older wing the rooms are not as big but they are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Residents are encouraged to personalise their rooms as sighted. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are spacious lounges in each area and there are also smaller lounges where residents can sit alone or in small groups. Each area has a dining room. Food is served from bain maries which come from the main kitchen. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is arranged to facilitate this. The dining rooms and large lounges accommodate lounge chairs. There is adequate seating and space to allow for individual and group activities to occur. There are tea/coffee making facilities for families and residents.  E3. 4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a cleaning policy and cleaning schedules in place. All cleaning chemicals are clearly labelled. Personal protective equipment is available in the cleaner’s cupboards and in the sluice rooms. The cleaning trolleys are locked in the cleaner’s cupboards when not in use. Safety data sheets are in the cleaner’s cupboards. Cleaners are observed to be wearing appropriate protective wear when carrying out their duties. Cleaning of carpets is carried out as required. There is a laundry policy. All laundry and personal clothing is laundered on site. There is a dedicated laundry person. There is a defined clean/dirty area within the laundry. Laundry chemicals are stored in a locked cupboard. Safety data sheets are on the door of the chemical cupboard. There is personal protective equipment in the laundry area. There are adequate linen supplies sighted in the linen cupboards. Laundry and cleaning staff have attended chemical safety training in May 2014. Laundry and cleaning internal audits have been completed |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate training information and equipment for responding to emergencies is provided. There is first aid trained staff across 24/7. The maintenance person is the fire safety officer. There is an approved fire evacuation scheme (sighted). Fire evacuations are held six monthly. There is a civil defence and emergency manual procedures manual in place. The facility has an emergency civil defence kit which is maintained by the health and safety officer (registered nurse). There is a spills kit maintained by the infection control coordinator (registered nurse). The facility has emergency lighting. There are gas barbeques that can be used for cooking. Emergency food supplies sufficient for three days are kept in the kitchen. There are extra blankets available. There are sufficient stocks of continence products and personal protective equipment. In the event of a power failure residents on oxygen concentrators can be switched to oxygen cylinders and there are back up batteries and torches. The call bell system operates in all areas. Key staff hold current first aid certificates. Staff ensure the building is secure overnight. Reception monitor visitor entry by day |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal rooms and bedrooms are well ventilated and light. The facility has heat pumps and gas heating. The temperature of the facility is comfortable. All bedrooms have external windows which let in natural light |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control co-ordinator (sighted) and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system.  The facility has access to professional advice within the organisation and has developed close links with the GP's, community laboratory, the infection control and public health departments at the local DHB. There are monthly infection control meetings.  Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The regional committees and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level.  There is a staff health policy. There have been no outbreaks since previous audit. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There is an infection control committee that meets monthly includes staff from across the facility. The facility also has access to the DHB infection control nurse, public health, community laboratory, GP's and expertise within the organisation. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.  There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.  Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.  External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control co-ordinator, the infection control committee and expertise from the governing body. Policies reviewed September 2014. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control co-ordinator is responsible for coordinating/providing education and training to staff. The IC co-ordinator is a registered nurse and completed external training. All training is mandated by Bupa and evaluated by staff who attend. Training has occurred in 2014 and through toolbox talks. Records of the evaluations were sighted. Resident education is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.  Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. 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. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is an organisational Restraint policy (251). There is a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint co-ordinators at each of the Bupa facilities. There are regular restraint meetings at the facility where all residents using restraint or enablers are reviewed. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.  The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has six residents using enablers (bedrails). There are two residents assessed as using a restraint. A register for each restraint is completed that includes a monthly evaluation.  The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | Only staff that have completed a restraint competency assessment are permitted to apply restraints. Staff restraint competency assessments are up to date.  There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisational level and at a service level. Interview with the restraint co-ordinator and review of her signed job description identifies her understanding of the role. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety.  On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. The three restraint residents' files included completed assessments that considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (table tops, bed rails, lap belts, and fall out chairs).  The restraint co-ordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.  The restraint co-ordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.  Monitoring charts were reviewed as being completed. Restraint use is reviewed through the monthly assessment evaluation, monthly restraint meetings and six-monthly multi-disciplinary meetings and includes family/whanau input.  A restraint register is in place providing an auditable record of restraint use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Evaluations occur monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families are included as part of this review. Restraint is evaluated on a formal basis monthly at the facility restraint meeting and six monthly by the regional restraint team. Evaluation timeframes are predetermined by risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. The service continues to minimise the use of restraint.  The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. Restraint education has been provided in 2014 and a restraint audit has been completed in Oct 2014 with 93% compliance. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | D7.1: Entries are legible, and signed by the relevant caregiver or registered nurse including designation. Dates and times are not routinely documented on care summaries and incident forms. | (i)Changes to interventions on care summaries were not always dated; (ii) follow up on incident forms by RNs were not always dated or included times. | Ensure dates and times are routinely documented by the writer  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication rooms/cupboards were checked across three areas.  Staff sign for the administration of medications on medication sheets held with the medications. Signing sheets correspond to instructions on the medication chart and all charts sampled evidenced that medication had been signed for. A list of specimen signatures and competencies are in each medication area | Three out of the nine medication charts sampled in the dementia wing showed PRN medications that are signed as given but without times. Times were documented in the progress notes and therefore a low risk has been awarded. | Ensure all PRN medications have the time given documented at the time at the time of administration  30 days |
| 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 | The initial assessment is completed within 24 hours and the initial care plan within 48 hours. The GP sees the resident within 48 hours of admission and thereafter monthly (hospital) or three monthly (rest home) or as required if health status changes. Two out of the ten permanent resident files were not evaluated within the six month time frame. Multidisciplinary reviews are also completed. The Physio and activities coordinator review files six monthly when the care plans are reviewed. Progress notes are written on each shift in the hospital. Progress notes are written every two or three days or whenever there is a change in health status in the rest home. In one of the rest home files sampled the progress notes reported an incident that was not followed up in the progress notes | (i) In two out of ten permanent resident files (rest home, hospital) the evaluations were not completed within the six month time frame. (ii) In the rest home tracers file and a dementia file, progress notes continuity of care was not documented, (iii) In one of the two rest homes files sampled the resident’s MNA was not completed although the resident was underweight | (i) Ensure evaluations are completed within the six month time frames or earlier as required; (ii) Ensure continuity of care is documented in all resident progress notes, (iii) Ensure risk assessments are completed on admission as per policy.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

|  |
| --- |
| No data to display |

End of the report.