# Bupa Care Services NZ Limited - Glengarry 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:** Glengarry Rest Home & Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services; Hospital services – Psycho-geriatric services; Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 19 January 2015 End date: 20 January 2015

**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:** 34

# 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

Glengarry Rest Home and Hospital is part of the Bupa group. The service is certified to provide hospital (medical and geriatric), rest home and dementia level care for up to 41 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

The facility manager at Glengarry has been in post for a number of years, and clinical manager in the role for three months. The manager has many years’ experience in aged care and management. There are systems being implemented that are structured to provide appropriate quality care for residents. An orientation and in-service training programme continues to be implemented that provides staff with appropriate knowledge and skills to deliver care.

There are two improvements required around staff meeting minutes and care plan interventions.

## 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. |

Glengarry endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan supporting practice. Cultural assessment is undertaken on admission and during the review process. 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. 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 and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

## Organisational management

|  |  |  |
| --- | --- | --- |
| 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. |

Glengarry is implementing the organisational quality and risk management system that supports the provision of clinical care. 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. There is one improvement required around meeting minutes. There are four benchmarking groups across the organisation focusing on rest home, hospital, dementia, psychogeriatric and mental health services. Glengarry is benchmarked in three of these (hospital, rest home and dementia). There are human resources policies to guide practice and an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of car. External training is 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. |

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the life style care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. The activities team implements the activity programme to meets the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings, and celebrations. Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the General Practitioner. Residents' food preferences and dietary requirements are identified at admission and all meals cooked on site. This includes consideration of any particular dietary preferences or needs.

## 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. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. The dementia unit is secure and provides a safe homelike environment for residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate.

## 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. The service has two residents on the register with an enabler and no restraint. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. 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 are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (facility manager) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator is supported by the Bupa quality and risk team. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

## Summary of attainment

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 | 42 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 2 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Bupa policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about the Code and competency questionnaires are also completed. Interview with five care givers, one enrolled nurse and one registered nurse demonstrate an understanding of the Code. Residents interviewed (two rest home and two hospital) and relatives (two rest home, one hospital and one dementia unit) confirm staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed ConsentConsumers 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 in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident on all resident files reviewed. There is evidence of general practitioner (GP) and family discussion regarding a clinically not indicated resuscitation status. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed with the admission agreements. Where legal processes are ongoing to gain EPOA this is recorded, as are letters of request to families for the supporting documentation. |
| Standard 1.1.11: Advocacy And SupportService 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 and information about advocacy services on entry. Interview with the facility manager and the clinical manager confirmed this occurs. Interview with four residents) confirmed that they are aware of their right to access advocacy. Interview with four family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the six files reviewed there was information on residents’ family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The activities policy encourages links with the community. This was seen to be implemented at Glengarry with the activities programmes including opportunities to attend events outside of the facility, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents and relatives interviewed informed visiting can occur at any time, and that the service encouraged involvement with community activities. Visitors were observed coming and going at all times of the day during the audit. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | There is a complaints procedure to guide practice. The facility manager has overall responsibility for managing the complaints process at Glengarry. A complaint management record has been completed for each complaint and a record of all complaints per month had been recorded on the register. The register included relevant information regarding the complaint including date of resolution. All supporting documentation was available. Verbal complaints are included and actions and response are documented. Complaints are reported to head office monthly. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. Discussion with four residents and four relatives confirmed they were provided with information on the complaint process. Complaint forms were visible for residents/relatives in various places around the facility.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. There is the opportunity to discuss these services prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed in the facility. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. The two monthly resident/family meetings also provide the opportunity for to raise issues/concerns (minutes sighted). Residents and relatives interviewed inform information has been provided around the Code and the complaints process.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | 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. Six resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified on admission and then integrated with the residents' care plan. This included cultural, religious, social and ethnic needs. There was evidence of family involvement. Interviews with four residents confirmed their values and beliefs were considered on admission. There were clear instructions provided to residents regarding personal belonging in the admission agreement. A tour of the facility confirmed there is the ability to support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms. There is an abuse and neglect policy is being implemented and includes staff in-service education. Interview with five caregivers described how choice is incorporated into resident cares. Interview with four residents informed staff are respectful. A resident satisfaction survey was completed in October 2014 that indicated an 88% overall satisfaction with the service (an increase of 4% on the previous year). |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | Bupa has a Maori health plan that aligns with contractual requirements. There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa’s facilities. Family/whanau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau. Values and beliefs are discussed at the initial care planning meeting and then incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with four relatives informed values and beliefs are considered. Discussion with four residents confirmed staff take into account their culture and values. Six care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: DiscriminationConsumers 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 responsibilities of the position and are in files reviewed. There are implemented policies to guide staff practice in respect of gifts. Clinical meetings occur two monthly and include discussion on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the clinical manager, and a registered nurse confirmed an understanding of professional boundaries.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Services are provided at Glengarry that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. These documents have been developed in line with 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. All Bupa facilities have a master copy of policies and procedures as well as related clinical forms. A number of core clinical practices also have education packages for staff which are based on their policies. There are four benchmarking groups monitored through Bupa, of which Glengarry is benchmarked against hospital, rest home and dementia indicators. Information is provided to staff on the trends and corrective action plans when indicators are above the benchmark (e.g. skin tears, falls) (link 1.2.3.6). Actions were reviewed and signed out. Bupa quality and risk management systems are being implemented at Glengarry.There is a learning and development fund that is available to support the on-going learning of all employees. All care givers are required to complete foundations level two as part of orientation. Bupa has introduced leadership development of qualified staff including education from HR, attendance at external education and Bupa qualified nurses’ education day and education session at monthly meeting. There are implemented competencies for care givers, enrolled nurses and registered nurses. The standardised annual education programme, core competency assessments and orientation programmes were all seen to be being implemented at Glengarry. Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). This continues to be implemented at Glengarry. Staff progress is reported at the staff meetings.Discussions with residents and relatives were positive about the care they receive. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff to their responsibility around open disclosure. Incident forms have a section to indicate if family have been informed (or not) of an event. Incident forms reviewed from across 2014 (all service types) identified that family had been notified following a resident incident. 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 October (2014) and confirmed family notification. Four relatives stated that they are informed when their family members health status changes. There is an interpreter policy and contact details of interpreters were available. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.The information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Glengarry is a Bupa facility with all service being on ground level. The service provides dementia, rest home and hospital level care for up to 41 residents. Occupancy on the day of audit was 34 residents – five in the dementia unit, 21 rest home and eight hospital level residents. The district health board physiotherapy services could be accessed by referral. Residents retained their own general practitioner on admission, there are three practices in Wairoa. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhanced their quality of life and minimised risks. Bupa have identified six key values that are displayed on the wall at Glengarry. There is an overall Bupa business plan and risk management plan and a documented purpose, values, and direction. Each facility is required to develop annual quality goals – Glengarry had been focusing on reducing skin tears and bruising in the hospital by 20% across the 2014 year. Progress towards goals were reported through the various meetings – for example the quality meeting full staff and clinical meeting. Glengarry participates in the organisations benchmarking programme that monitors key aspects of care.The facility manager at Glengarry is an experienced manager (RN) with a current practising certificate and has an aged residential care background. She is supported by a clinical manager (registered nurse) who oversees clinical care and has been in the role for three months. The management team was supported by the wider Bupa management team that included an operations manager. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six monthly. The manager has maintained at least eight hours annually of professional development activities related to managing a 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 | During a temporary absence, the clinical manager will cover the manager’s role supported by the operations manager. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Glengarry was implementing the Bupa quality and risk management system which is designed so that key components are linked to facility operations. The quality committee meet two monthly and outcomes are then reported across the various meetings including the staff meetings, clinical meetings and health and safety meetings. Meeting minutes reviewed do not always include discussion about the key components of the quality programme. Resident and relative meetings are held one to two monthly and issues raised are seen to have been followed through.Policy review is coordinated by Bupa head office. A policy and procedure review committee meets monthly to discuss the policies identified for the next two policy rollouts. Facility staff have the opportunity to provide feedback during the review process. Policy documents have been developed in line with current best and/or evidenced based practice. Facilities have a master copy of all policies and procedures and the related clinical forms. Facility staff are informed of changes/updates to policy at the various staff meetings. A number of core clinical practices also have education packages for staff which are based on policies. The quality programme includes an annual internal audit schedule that was being implemented at Glengarry. Audit summaries and corrective action plans (CAPs) are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee e.g. quality, health and safety. CAPs are seen to have been implemented and closed out. Monthly clinical indicator data is collated across the facility monitoring rest home, hospital and dementia services. There is evidence of trending of clinical data, and development of CAPs when volumes exceed targets – e.g. skin tears. There are falls prevention strategies are in place that include, hi/lo beds, ongoing falls assessment and exercises by the physiotherapist, and sensor mats. Interview with staff confirmed an understanding of the quality programme.Bupa has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Glengarry was focusing on reducing the rate of skin tears and bruising for the 2014 year. Variable results had been achieved against this objective. The CAP process is used to plan and evaluate progress towards specific objectives. Glengarry was also working on improving the manager score resulting from the global people score (GPS). This objective was met with the result exceeding target. Glengarry was in the process of confirming 2015 objectives at the time of audit. Quality Action Forms (QAF) are implemented in response to a facility quality initiative. There were a number of examples at Glengarry including environmental improvements to the dementia unit, monthly mapping of pressure injuries and establishment of a reminder system to three monthly general practitioner reviews.There is a health and safety, and risk management programme being implemented at Glengarry. The health and safety committee met one to two monthly and minutes reviewed included discussion of incidents/accidents. There is a safety representative who has attended training. There was a current hazard register.Interview with staff demonstrated an understanding of the quality management programme. |
| 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 | Glengarry collects incident and accident data on the prescribed form. Forms reviewed had been completed comprehensively, reviewed by the clinical manager (or delegate) and signed off. Monthly analysis of incidents by type was undertaken by the service and reported to the various staff meetings (link 1.2.3.6). Data was linked to the organisation's benchmarking programme and used for comparative purposes. CAPs were created when the number of incidents exceeded the benchmark – e.g. falls. CAPs were seen to have been actioned and closed out. Senior management were aware 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 | There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are also job descriptions for the infection control coordinator, restraint coordinator, and health and safety officer. Appropriate recruitment documentation was seen in the seven staff files reviewed (two care givers who work across the service areas, one cook, one registered nurses who is take over the role of infection control officer, one activities coordinator, the clinical manager who is the restraint officer and the facility manager who is the infection control officer at the time of audit). A register of practising certificates was maintained. Performance appraisals were current in all files reviewed. Interview with the management team (facility manager, clinical manager) inform a relatively stable workforce at the time of audit. Interview with five care givers, one dementia unit coordinator and one registered nurse inform management were supportive and responsive. There is an annual training plan that was being implemented and in addition ‘tool box’ sessions were seen to have been provided opportunistically. Bupa ensures registered nurses (RN) were supported to maintain their professional competency. There is an RN/EN training day provided through Bupa that covers clinical aspects of care - e.g. wound management. External education is available via the DHB. A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies had been completed annually and a record of completion maintained.There is a comprehensive orientation programme being implemented with completion of prescribed modules being completed by new employees. Completion of requirements is monitored. Interview with staff informed the orientation programme meets the requirements of the service. The clinical structure in the facility includes a facility manager (practising registered nurse), clinical manager, enrolled nurse coordinator in the dementia unit, registered nurses in the rest home/hospital areas and a team of care staff. There were ten caregivers employed to work in the dementia unit and all had completed dementia standards. Interview with caregivers informed they are not able to work in the dementia unit without having completed the required standards. |
| 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 that aligns with contractual requirements. 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 registered nurse and first aid trained member of staff on every shift. There is an enrolled nurse coordinator in the dementia unit. Interviews with five caregivers inform the registered/enrolled nurse/s are supportive and approachable. Staff interviewed informed there are sufficient staff on duty at all times. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in locked cupboards. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. |
| 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 | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.Information gathered at admission is retained in resident’s records. Four relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whanau at entry including admission to dementia. An advocate is available and offered to family. The admission agreement reviewed aligns with a) -k) of the ARC contract. Six of six admission agreements viewed were signed. 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 | Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. |
| 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. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There is a medication room for rest home and hospital and one for the dementia unit. All medications were securely and appropriately stored. Registered nurses or senior caregivers administer medications who have passed their competency administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. The service uses robotic packs. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines and this was documented and up to date in all 12 medication signing sheets reviewed. The medication folders include a list of specimen signatures and competencies. Medication profiles reviewed were legible, up to date and reviewed at least three monthly by the G.P. All 12 medication charts reviewed have as needed medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service employs one cook and one relieving cook, both have completed food safety certs. There is a well equipped kitchen and all meals are cooked onsite. There is dining room for rest home and hospital residents next to the kitchen. Meals are plated and delivered to the dementia unit. On the day audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and documented daily and daily in other areas, these were within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets were noted on the kitchen notice board which is able to be viewed only by kitchen staff. The national menus have been audited and approved by an external dietitian. Residents and families interviews were very happy with meals provided.There was evidence that there are additional nutritious snacks available over 24 hours. |
| 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 | The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry was declined. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Bupa assessment booklets and lifestyle templates were comprehensively completed for all six resident files reviewed. The assessment booklet provides in-depth assessment across all domains of care. Additional risk assessment tools include behaviour, restraint and wound assessments as applicable. Risk assessments are completed on admission and reviewed six monthly as part of the support plan review. Additional assessments for management of behaviour, wound care and restraint were appropriately completed according to need. For the six resident files reviewed formal assessments and risk assessments were in place and reflected into care plans.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Service delivery plans (lifestyle care plans) were comprehensive and demonstrate service integration and demonstrate input from allied health. All six resident lifestyle care plans were resident centred and documented an in-depth knowledge of resident care and support needs. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Lifestyle care plans in the dementia unit detailed care and support for behaviours that challenge, including triggers and management. Short term care plans were in use for changes in health status and were evaluated on a regular basis as resident needs change. There was evidence of service integration with documented input from a range of specialist care professionals. Psycho-geriatrician support and advice is documented in dementia care resident files. |
| 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 | Six resident care plans reviewed. All have care plan documentation that meets resident need, all care plan had been updated as resident needs changed. Interview with two GPs evidenced that care provided is of a high standard and GPs are kept informed. Four family members agreed that the clinical care is good and that they are involved in the care planning. Caregivers (five) and RNs (two) interviewed state there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for 11 residents (two hospital, five rest home and two resident with more than one wound in the dementia unit). There are three resident with pressure areas. All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support in available as needed. Care plans document allied health input. Formal monitoring of resident care is an area for improvement. |
| Standard 1.3.7: Planned ActivitiesWhere 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 is an activities coordinator who works 30 hours per week. The activities coordinator provides activities in the hospital and rest home and plans activities for the dementia unit, most of which are run by the enrolled nurse and caregivers. The activities coordinator has training around dementia care and needs. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The residents in the dementia unit were engaged and active on the day of audit. The Bupa activities programme template is designed for high end and low end cognitive functions and caters for the individual needs. The programme is developed monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans are evaluated by the registered nurse six monthly or when changes to care occur as sighted in five long term resident files sampled. In the dementia unit the enrolled nurse reviews and care plans signed by the registered nurse. One resident has not been at the service long enough for a review. Short term care plans for short term needs were evaluated and either resolved or added to the long term care plan as an on-going problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| 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. There was evidence of where a resident’s condition had changed and the resident was reassessed for a higher level of care from rest home to hospital level of care. Discussion with the clinical manager identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services. |
| 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 are comprehensive and up to date policies that include chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas in all services. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.  |
| 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 which expires on 1st June 2015. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a 52 week planned maintenance programme in place. Hot water temperature has been monitored weekly in resident areas and were within the acceptable range. The living areas and bedrooms have vinyl surfaces as do bathrooms/toilets and kitchen areas. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. The dementia unit is secure from the rest of the facility. There is a secure external courtyard developed off the dementia unit with fencing extended to include more space for dementia. The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate. In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. There is outside areas that include shade around the facility. E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities and there is a garden/path and grass area with outdoor furniture and a fountain at one end. ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, three hoists (one standing and two sling), heel protectors, lifting belts. E3.3e: There are quiet, low stimulus areas that provide privacy when required. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | There are adequate toilets and showers in the rest home/hospital with five toilets and three showers. In the dementia unit there are two toilets and one shower. Resident rooms have hand basins in the dementia unit. One room in the hospital has a shower/toilet ensuite. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Communal toilets and bathrooms have appropriate signage and locks on the doors.  |
| 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 | Rest home/hospital: Residents rooms hospital and rest home wing are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in the one ensuite. The open plan lounge area is spacious and can be used for activities and small groups as well as for private chats. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley or wheelchair. Dementia unit: There are nine individual bedrooms in the dementia unit. Mobility aids can be used in the dementia unit in all rooms including bedrooms. Bedrooms are large enough to include a lazy boy chair and extra equipment if required.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a combined lounge/dining room in the dementia unit. Activities occur throughout the facility and in the lounge areas. Activities are to occur in any of the lounges and they are all large enough to not impact on other residents not involved in activities. Seating and space is arranged to allow both individual and group activities to occur. 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 ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is undertaken on site, there is a small but well organised laundry is divided into a “dirty” and “clean” area and staff manage adequately. There are appropriate systems for managing infectious laundry which staff can describe. There is a comprehensive laundry manual, cleaning and laundry services are monitored throughout the internal auditing system and the resident satisfaction surveys. The cleaners trolleys were attended at all time or locked away in the cleaning rooms as sighted on the day of the audit. There is a sluice room for the disposal of soiled water or waste in the hospital and this can be used by staff in the dementia unit and this is transported to the sluice room in a bucket with a lid.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR was included in the mandatory in-service programme. There was a first aid trained staff member on every shift. Glengarry has an approved fire evacuation plan and fire dills occur six monthly. Smoke alarms, sprinkler system and exit signs were in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is in place for four hours, hoists have battery backup and oxygen cylinders are available. There is a civil defence kit in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.  |
| 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 | The facility is light and airy. There is overhead heating in each bedroom and panel heaters in the main areas. Smoking is only allowed outside away from residents' rooms and communal areas in a designated outdoor area. |
| Standard 3.1: Infection control managementThere 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 is appropriate for the size and complexity of 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 (IC) coordinator and clearly defined guidelines. The infection control programme is linked into the quality management programme. The infection control committee meets bimonthly at Glengarry. The quality meetings reviewed also included a discussion of infection control matters (link 1.2.3.6). The IC programme is reviewed annually at head office. The facility had developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. Bupa have a regional infection control group (RIC) for the three regions in NZ (minutes sighted).  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the facility manager, the clinical manager, an RN (who is taking over the role of IC coordinator from the facility manager), and other staff. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation. |
| Standard 3.3: Policies and proceduresDocumented 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 | 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.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator (facility manager who, at the time of audit was working with one of the registered nurses to take responsibility for the portfolio). The facility manager is suitably skilled to manage infection matters and the registered nurse who is to become the IC coordinator is booked for training in February. The orientation package includes specific training around hand washing and standard precautions and there is scheduled infection control training as part of the annual education schedule. Tool box sessions are also used opportunistically to maintain staff knowledge. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.  |
| Standard 3.5: SurveillanceSurveillance 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 the purpose and methodology for the surveillance of infections. The IC coordinator 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 IC coordinator. 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 (link 1.2.3.6). 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 minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a regional restraint group at an organisation level that reviews restraint practices and also monthly 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. Glengarry is a restraint free environment. There were two residents with enablers in the hospital, both of which were bedrails. Both of these residents have a documented three monthly review of the enabler in use. 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. |

# 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 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data was collated monthly and reported to head office. Monthly data included clinical indicators such as skin tears, falls, medication errors and the like. Complaint activity, internal audit outcomes and CAP activity is also reported. There is a prescribed meeting schedule that was being implemented at Glengarry that included a two monthly quality meeting and various other meeting. Key components of the quality system are generally seen to have been discussed.  | A review of the meeting minutes show not all aspects of the quality programme are discussed at the various meetings – for example while skin tears and bruising data is minuted, there is no mention of falls, medication errors and/or incidents. There had been instances where the number of falls, medication incidents and infections had exceeded the monthly target.  | Meeting minutes include discussion of all aspects of the quality management programme.180 days |

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| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Care plans reviewed are comprehensive and well documented. Discussion with staff evidences that they are well informed regarding the care needs of the residents. Observation and discussion with residents and their family evinces that care provided is safe and caring. | One resident with a syringe driver did not have the formal monitoring of the syringe driver documented. This same residents pain monitoring was documented as a result of the resident expressing pain rather than a pro-active monitoring and checking process. One resident with an enabler did not have documented monitoring as per plan.  | Ensure documentation reflects that monitoring occurs.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.

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End of the report.