# Bupa Care Services NZ Limited - Avondale Rest Home & Hospital

## Introduction

This report records the results of a Surveillance 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:** Avondale Rest Home & Hospital

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

**Dates of audit:** Start date: 16 April 2015 End date: 16 April 2015

**Proposed changes to current services (if any):** Addition of 11 beds suitable for either hospital or rest home level care as required.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 66

# 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

Avondale Rest Home and Hospital provides rest home, hospital and dementia level care for up to 67 residents. On the day of audit, there were 66 residents. The service is managed by a care home manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

This audit also included reviewing the suitability of 11 current resident rooms to provide either rest home or hospital level care. These bedrooms are located in close proximity to the nurses’ station in the wing that is predominately rest home level residents. Four of these eleven beds were occupied by hospital level residents at the time of the audit. These rooms have been assessed as suitable as dual-purpose rooms.

The service has addressed the two shortfalls from the previous certification audit around podiatry services and the activities programme. The surveillance audit identified that improvements are required in relation to medication management.

There is one area of continuous improvement awarded around the infection control surveillance programme.

## Consumer rights

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

There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |  | Standards applicable to this service fully attained. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. Corrective actions are implemented where opportunities for improvements are identified. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. On-going education and training for staff.

Registered nursing cover is provided 24 hours a day, seven days a week.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| 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 care plan development with input from residents and family. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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. |

A current building warrant of fitness is posted in a visible location.

## 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. |

Enablers are voluntary and the least restrictive option. There were no residents who required enablers during the audit.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

## 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** | 1 | 14 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 1 | 37 | 0 | 1 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the care home manager using a complaints’ register. Documentation including follow up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Follow-up documentation to the complainant includes information relating to the Health and Disability Advocacy Service.  Discussions with six residents (three rest home level and three hospital level) and five relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are located in a visible location at the entrance to the facility. One complaint received in 2015 that was selected for review reflected evidence of responding to the complaint in a timely manner with appropriate follow-up action taken. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.  Evidence of communication with family/whanau is recorded on the family/whanau communication record, which is held in the front of each resident’s file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms that were reviewed across the rest home, hospital and dementia unit identified family are kept informed. Five relatives interviewed (one with a relative in the rest home, one with a relative in the hospital and three with relatives in the dementia unit) stated that they are kept informed when their family member’s health status changes.  An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.  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 are not covered by the agreement. |
| 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 Avondale is a Bupa residential care facility, situated in Avondale, Auckland. The service currently provides care for up to 67 residents at hospital, rest home and dementia levels of care. On the day of the audit there were 26 hospital level residents, 25 rest home residents and 15 dementia level residents.  On 26 July 2013, HealthCERT notified the provider of the approval of 11 beds for rest home or hospital level care. The auditors were requested to determine the suitability of these beds when onsite for the facility’s next audit. Based on auditor inspections, review of staffing, equipment and interviews with the care home manager and staff, these eleven rest home level beds have been determined by the auditors to be suitable for either rest home or hospital level care. Four of the eleven beds were filled with hospital level residents at the time of the audit.  A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan.  The facility is managed by an experienced care home manager who has worked in aged care for many years and at this facility for the past three years. She is supported by a clinical manager/registered nurse.  The facility manager has maintained over eight hours annually of professional development activities related to managing an aged care service. |
| 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 | A quality and risk management programme in place. Interviews with the care home manager, nurse manager and staff (three caregivers, two registered nurses, one diversional therapist and one chef) reflect their understanding of the quality and risk management systems that have been put into place.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents’ falls, infection rates (link 3.5.7), complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Quality data is benchmarked against other similar Bupa facilities. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are being implemented and signed off by the care home manager when completed.  Falls prevention strategies are in place that includes the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. A health and safety programme (Bfit) is in place, which is linked to the overarching Bupa National Health and Safety Plan. Health and safety goals are reviewed annually. Hazard identification forms and a hazard register are in place. The organisation holds tertiary accreditation by ACC for their workplace safety 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 | Individual reports are completed for each incident/accident with immediate action noted and any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Data collected on incident and accident forms are linked to the quality management system.  The managers are aware of their 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 human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files that were randomly selected for review (three caregivers, one registered nurse and one clinical manager) included evidence of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service.  There is an annual education and training schedule. Opportunistic education is provided via toolbox talks. Aged Care Education (ACE) is undertaken by the caregivers. Education and training for registered nursing (RN) staff is linked to completion of the Professional Development and Recognition Programme (PDRP). Four out of nine RN’s have submitted their PDRP portfolios.  At the time of the audit there were six caregivers rostered to work in the dementia unit. Four of the six caregivers have completed the required dementia New Zealand Qualifications Authority (NZQA) standard. One of the six caregivers has been employed for less than one year and has enrolled in the dementia training programme. The other caregiver is in her third year of training as a registered nurse (RN). Because she has not completed the NZQA dementia training programme, the care home manager removed her from the dementia unit roster. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The facility manager and clinical manager are registered nurses who are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. Interviews with the residents and relatives confirmed staffing overall was satisfactory.  Eleven beds in the rest home wing are suitable as beds that can swing to either rest home or hospital level of care. The care home manager has a staffing plan that matches resident acuity in the rest home wing. Swing beds are in close proximity to the rest home nursing station. At the time of the audit, there were four hospital level residents living in this wing. |
| 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 | Bupa has comprehensive medication policies in place. The service uses individualised medication packs which are checked in on delivery by registered nurses. A registered nurse and medication competent caregiver were observed administering medications correctly. Medications and associated documentation are stored safely and securely and all medication checks are completed and meet requirements. Medications charts reviewed had three monthly medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 12 medication charts reviewed. An annual medication administration competency is completed for all staff administrating medications and medication training has been conducted.  There is a self-medicating resident’s policy and procedures in place. There were two residents who self-administered medications with competencies completed and reviewed three monthly. Individually prescribed resident medication charts were in use and this provides a record of medication administration information. Four of 12 medication charts reviewed did not record ‘indication for use’ of ‘as required’ medication by the GP. As required medication is reviewed by a registered nurse each time prior to administration. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. |
| 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 meals at Bupa Avondale are prepared and cooked on site. The service employs a kitchen manager, cooks and kitchen assistants. The kitchen is able to cater for the increase in dual purpose residents’ rooms. There is a six weekly winter and summer menu. The national menus have been audited and approved by an external dietitian. Meals are prepared in a well-appointed kitchen and served to residents in each dining room from bain maries. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Special eating utensils were available for residents to use. Diets are modified as required. 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 and the kitchen manager meets with residents to gain feedback about the service and food choices. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets are catered for. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. There are snacks/nibbles available over 24 hours for residents. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurses initiate a review and if required, GP, contracted geriatrician, gerontology nurse specialist or specialist consultation.  The caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. Residents and families interviewed were complimentary of care received at the facility. The care being provided is consistent with the needs of residents; this is evidenced by discussions with three caregivers (one from each service level), one registered nurse from the dementia unit and one unit coordinator (RN) from the hospital, five families interviewed, and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status. Dressing supplies are available and a treatment room is stocked for use. Residents toe nails are checked by the registered nurses and referred to the podiatrist for treatment when required. A log is kept of all podiatry referrals and treatment. This was a previous finding that has now been addressed. Wound assessment and wound management plans are in place for eight wounds. One resident has two skin tears. Three residents with venous ulcers have had input from the wound nurse specialist. All wound assessments have completed short term care plans describing appropriate interventions. All wounds have been reviewed within the required timeframes. |
| 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 is one diversional therapist (DT) and one activities assistant who are regularly supported by the Bupa regional occupational therapist. There is a full and varied activities programme in place which is appropriate to the level of participation from residents with regular outings. On the day of audit residents in all areas were observed being actively involved with a variety of activities. The programme is developed monthly by the DT with input from residents, families and the activity assistant, and displayed in large print in communal areas and resident bedrooms. There are three programmes developed (one for each service level) and all three programmes, with clearly identified location of activity, are displayed in each area. Residents can attend any activity and this was observed on the day of the audit. The activities staff provide an activities programme over five days each week. There are activities arranged that are delivered by caregivers in the dementia unit when activity staff are not present. These include a variety of activity including cognitive, sensory and physical activity. The DT trains caregivers so they are able to deliver activities for residents in the dementia unit. Residents have an activities assessment completed over the first few weeks after admission and activities are included in the care plans. Residents in the dementia unit have a 24 hour activity plan developed. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents and felt that recreational needs were being met. The activity programme is able to accommodate the increase in dual purpose rooms.  The service has addressed previous audit findings around activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans evaluations reviewed were completed at least six monthly and were updated as changes were noted in care requirements. Care plan evaluations were comprehensive, relate to each aspect of the care plan and record the degree of achievement of goals and interventions. Short term care plans were evidenced as utilised for residents and any changes to the long term care plan were dated and signed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry date 22 June 2015). |
| 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. | CI | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control 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 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 meetings include the monthly infection control report. 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. Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The service is commended for their continued improvement approach around follow up actions of infections and clinical indicators. There have been outbreaks over the last two years. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had no residents using enablers or restraints. |

# 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Eight medication charts reviewed had documented reason for use of as required medications by the GP to safely guide staff. Registered nurses, enrolled nurses and senior caregivers administered medications. When a resident required ‘as required medications’ the registered nurse either administers the medication or is consulted by the senior caregiver prior to the medication being administered. This ensured the medication is administered according to the residents need such as analgesia for pain | Four of 12 medication charts reviewed did not record indication for use of ‘as required’ medication by the GP so as to safely guide staff. | Ensure that reason for use of as required medication is documented on the residents medication chart by the GP.  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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | Infection control data is collated monthly and reported to the quality and health and safety meeting. The meetings include the monthly IC report. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality management programme. Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. There are a number of internal audits completed including (but not limited to) standard precautions, environmental hygiene (cleaning, laundry, kitchen and nursing) and food service | The service has continued to undertake a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC stats were discussed at RN/EN meetings and corrective actions were implemented when infections increase. Incident/infection - analysis tool was utilised to assist with identifying trends. Quality Improvement Plans (QIPs) have been developed for each “red flag” identified in the benchmarking indicators and toolbox talks provided to staff and residents around urinary infections, eye infections, respiratory infections and wound infections. Infection stats, trends and education are regularly provided via noticeboards and meetings to staff, residents and relatives. Benchmarking with other Bupa facilities and graphing of data is undertaken monthly. The infection control co-ordinator has completed infection training including outbreak management and has been in the role for three years. There are regional teleconferences three monthly for infection control coordinators and resources available and accessible. The infection control committee which includes the infection control co-ordinator, clinical manager, an RN, a caregiver, the kitchen manager and a household representative. The committee met two monthly and reported information back to the two monthly quality and risk meeting. Minutes are available in the staff room for all staff to read. |

End of the report.