Bupa Care Services NZ Limited - BeachHaven 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.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	BeachHaven Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Residential disability services - Physical
Dates of audit:	Start date: 13 April 2015 End date: 14 April 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: 98

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

Indicator	Description	Definition
	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

Beachaven is part of the Bupa group. The service is certified to provide hospital (medical, geriatric and psychogeriatric), physical and intellectual disability care for up to 99 residents.

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

The care home manager and clinical manager at Beachaven have been in their respective posts for a number of years. The care home 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. Residents and family advised that the staff provide a caring and homely environment.

The service is commended for achieving three continued improvements ratings related to implementation of quality initiatives/outcomes and good practice.

This audit identified no areas requiring improvements.

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

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

Beachaven 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 relative newsletters. Quality and risk performance is

reported across the facility meetings and to the organisation's management team. Quality initiatives are implemented which provide evidence of improved services for residents. Various quality programmes evidence that continuous improvements are achieved. There are four benchmarking groups across the organisation focusing on rest home, hospital, dementia, and psychogeriatric/mental health services. Beachaven is benchmarked in two of these (hospital and psychogeriatric). 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

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.		Standards applicable to this service fully attained.

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 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 review by the general practitioner at least every three months. 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

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 psychogeriatric 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

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 25 residents on the register with restraint and no enablers. Restraint includes bedrails for 14 residents, one seating restraint, and eight residents with environmental 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

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 officer (clinical nurse manager) is responsible for coordinating/providing education and training for staff. The infection control officer 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.

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	2	48	0	0	0	0	0
Criteria	3	98	0	0	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.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	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 have been provided with information on admission which includes the Code. Staff have received training about the Code and competency questionnaires are also completed. Interviews with 10 care givers, one enrolled nurse and five registered nurses demonstrate an understanding of the Code. Two hospital residents and eight relatives (five hospital and three psychogeriatric) interviewed confirm staff respect privacy, and support residents in making choice where able.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and	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 on-going to gain EPOA this is recorded, as are letters of request to families for the supporting documentation.

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code and information about advocacy services on entry. Interview with the care home manager and the clinical manager confirmed this occurs. Interview with residents confirmed that they are aware of their right to access advocacy. Interview with family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the files reviewed there was information on residents' family/whanau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The activities policy encourages links with the community. This was seen to be implemented at Beachaven with the activities programmes including opportunities to attend events outside of the facility. 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 care home manager has overall responsibility for managing the complaints process at Beachaven. 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. 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 residents and 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 Delivery Consumers 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 have been 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 monthly relative newsletter, MDT meetings and three times yearly relative parties also provide the opportunity to raise issues/concerns. Residents and relatives interviewed confirm information has been provided around the

		Code and the complaints process.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	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. Ten 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. There was evidence of family involvement. A tour of the facility confirmed there is the ability to support personal privacy for residents. There is an abuse and neglect policy which is being implemented and includes staff in-service education.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	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 Beliefs Consumers receive culturally safe services which recognise and	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 have been 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 residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The Code of Conduct is included in the employee pack. Job descriptions include responsibilities of the position and are in files reviewed. There are implemented policies to guide staff practice in respect of gifts. Clinical meetings occur three monthly and a nurse's forum has taken place fortnightly. Both meetings 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 six registered nurses confirmed an understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Services are provided at Beachaven that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. 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 across Bupa, of which Beachaven is benchmarked against hospital and psychogeriatric indicators. Information is provided to staff on the trends and corrective action plans when indicators are above the benchmark (e.g. skin tears, falls). Actions were reviewed and signed out. Bupa quality and risk management systems are being implemented at Beachaven. 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 Beachaven. 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 Beachaven. Staff progress is reported at the staff meetings. Discussions with residents and relatives were positive about the care they receive.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	There is an incident reporting policy to guide staff on their responsibility around open disclosure. Incident forms reviewed identified that family had been notified following a resident incident. 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

provide an environment conducive to effective communication.		is available in large print and this can be read to residents. Information specific to the Psychogeriatric unit is provided to family on admission.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Beachaven is a Bupa facility which provides hospital and psychogeriatric level care for up to 99 residents. Occupancy on the day of audit was 98 residents – 32 residents live in the Tui psychogeriatric unit, 27 hospital residents live in the East wing and there were 39 residents in Kowhai hospital unit. (Kowhai unit includes 11 residents who are assessed as psychogeriatric level of care). Kowhai is a secure unit which maintains a safe environment for the 11 psychogeriatric residents. Of the remainder of residents (28 hospital) who also live in this unit only eight of these residents are able to mobilise. These eight residents have been assessed for environmental restraint (link #2.1). The district health board is aware of this arrangement. Visitors and hospital residents are able to come and go as desired. The philosophy of the service includes providing safe and therapeutic care for residents requiring specialised dementia care and hospital care. Bupa have identified six key values that are displayed on the wall at Beachaven. 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 – Beachaven had been focusing on reducing the incidence of bruising by 30% across the 2015 year. Progress towards goals were reported through the various meetings – for example the quality meeting full staff and clinical meetings. Beachaven participates in the organisations benchmarking programme that monitors key aspects of care. The care home manager at Beachaven 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 many years. The management team is supported by the wider Bupa management team that includes 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	FA	During a temporary absence, the clinical manager provides cover for 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.

effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
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.	CI	Beachaven continues to implement 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 other meetings. Meeting minutes reviewed include discussion about the key components of the quality programme. Policy review is coordinated by Bupa head office. The service has comprehensive policies/ procedures to support service delivery. The quality programme includes an annual internal audit schedule that was being implemented at Beachaven. 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 and annual reviews are completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings are held. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
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	FA	Beachaven collects incident and accident data on the prescribed form. Forms reviewed had been completed comprehensively, reviewed by the clinical manager and signed off. Monthly analysis of incidents by type has been undertaken by the service and reported to the various staff meetings. Data was linked to the organisation's benchmarking programme and used for comparative purposes (also link CIs in 1.2.3.6 and 1.2.3.7). CAPs were created when the number of incidents exceeded the benchmark – e.g. bruising. 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

their family/whānau of choice in an open manner.		
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	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files were reviewed and included all appropriate documentation. Staffing levels are stable with some staff having been employed for a number of years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. There is a completed in-service calendar for 2014 which exceeds eight hours annually. Caregivers have completed either the national certificate in care of the elderly or have completed or commenced the career force aged care education programme. The manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local DHB.
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 minimum of two registered nurses plus care staff on every shift. Interviews with 10 caregivers inform the nursing staff and management 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	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 caregiver 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.

required.		
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. 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 PG unit. An advocate is available and offered to family. The admission agreement reviewed ARC and ARHSS contract. Ten 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 each 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. 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 20 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 20 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 Management A 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 certificates. The housekeeper services manager oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals are cooked onsite. There is a separate dining room in each area kitchen. Meals are delivered to the psycho-geriatric unit in a bain marie and plated in the 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 occurs 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	FA	Bupa assessment booklets and LTCPs reviewed were comprehensively completed for all ten resident files reviewed. The assessment booklet provides in-depth assessment across all domains of care. 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 ten resident files reviewed, InterRAI assessments and risk assessments were in place and reflected into care plans.

in a timely manner.		
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed were comprehensive and demonstrate service integration and demonstrate input from allied health. All ten resident care plans were resident centred and documented in detail support needs. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Long term care plans in the psychogeriatric unit (PG) detail care and support for behaviours that challenge, including triggers, associated risks and management. Short term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. There was evidence of service integration with documented input from a range of specialist care professionals. Psychogeriatrician support and advice is documented.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans reviewed included documentation that meets the need of the residents, and all care plans had been updated as residents` needs changed. Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members agreed that the clinical care is good and that they are involved in the care planning. Caregivers and RNs interviewed state there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. Wound management and monitoring occurred as planned. 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.
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 activities coordinator (40hrs week) and 2 activities assistants; (30hrs week). On the day of the audit, one activities coordinator was on leave and one activities coordinator had recently resigned. Activities were provided by care givers that temporarily filled in for the absent activities coordinator. A contracted physiotherapist assists with the exercise and walking groups. A physio assistant assists with walking, mobility and transfer. The activities coordinator has received 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 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 an 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. The residents' activity care plans have de-escalating techniques for residents with behaviour that might challenge.
Standard 1.3.8:	FA	Care plans reviewed were evaluated by the registered nurses six monthly or when changes to care occurs. In the hospital unit; whenever the enrolled nurse reviews care plans it is signed by the registered nurse. Short term care

Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		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 resident/family, Care home and clinical manager. 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 with residents being seen monthly. 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 or different 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. The maintenance person described the safe management of hazardous material.

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 26 April 2015 and awaiting the new issue. 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 monthly in resident areas and was 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 psychogeriatric unit and one wing with mixed level of care (hospital level and PG) are secure from the rest of the facility. There is a secure external courtyard developed for the psychogeriatric unit with fencing extended to include more space. The facility has a van available for transportation of residents. Those staff transporting residents holds a current first aid certificate. The person responsible for maintenance described the heating available in the facility. In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. There are quiet, low stimulus areas that provide privacy when required.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate toilets and showers in the hospital units and PG unit. Resident rooms in the PG unit and hospital have hand basins and ensuite facilities. 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	FA	Residents' rooms in the hospital and PG 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 ensuite facilities. The open plan lounge areas are spacious and can be used for activities and small groups as well as for private social interaction. Residents requiring transportation between rooms or services are able to be moved safely from one area to

provided with adequate personal space/bed areas appropriate to the consumer group and setting.		another. Staff interviewed reported that they have adequate space to provide cares to residents.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	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. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is undertaken on site, there is a well organised laundry and is divided into a “dirty” and “clean” area and staff manage the workload adequately. There are appropriate systems for managing infectious laundry which laundry staff could 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 in each part of the facility for the disposal of soiled water or waste.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an	FA	There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There was a first aid trained staff member on every shift. The facility 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 has gas

appropriate and timely response during emergency and security situations.		facilities for cooking in an event of a power failure with a backup system for emergency lighting and battery backup. 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 has plenty of natural light. There is overhead heating in the corridors and panel heaters in the main areas. Smoking is only allowed outside and away the facility. The facility and grounds are a smoke free area.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme 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 Beachaven. The quality meetings reviewed also included a discussion of infection control matters. The IC programme is reviewed annually at head office. The facility has 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.
Standard 3.2: Implementing the infection control programme There are adequate	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 nurse manager (IC officer), an RN, a house hold staff member, activities staff member and house hold manager. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.

human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	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 officer is responsible for coordinating/providing education and training to staff. The IC coordinator (clinical nurse manager) is suitably skilled and trained to manage infection matters. The orientation package for new staff includes specific training around hand washing and standard precautions. There has been infection control training provided 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: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes 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. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a regional restraint group at an organisation level that reviews restraint practices. The Beachaven quality committee is also responsible for restraint review and use. 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 is restraint is and what is an enabler. The restraint policy includes comprehensive restraint procedures. There are no residents with enablers. There are a total of 23 residents on restraint. This includes 10 hospital and four psychogeriatric residents with bedrails; one psychogeriatric resident who is placed on a bean bag; and eight hospital residents with environmental restraint. These eight residents are mobile hospital residents who reside in Kowhai hospital unit. This unit is a locked unit which can been accessed by staff and visitors and exited via key pad lock. All restraint use is recorded on a restraint register. Files for four residents with restraint (including environmental restraint) were reviewed. All files evidenced that a documented three monthly review of restraint has been conducted. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure),	FA	The restraint coordinator is the care home manager (registered nurse). The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions included the restraint coordinator, clinical manager, registered nurses, resident/or family representative and medical practitioner. Restraint use and review is part of the quality team meeting.

duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, clinical manager, registered nurses, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. Assessments and approvals for restraint were fully completed (including environmental restraint). These were sighted in the four files reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are followed. There is an assessment form/process that was completed for all restraints including the environmental restraint for eight hospital residents. The four files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. Consent forms detailing the reason and type of restraint were completed. In resident files reviewed, appropriate documentation has been completed. The service had a restraint and enablers register which was up dated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the four restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices were reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings. Evaluation timeframes were determined by risk levels. The evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews were completed three monthly or sooner if a need is identified. Reviews were completed by the restraint co-ordinator and/or clinical manager. Any adverse outcomes were included in the restraint co-ordinators monthly reports and were reported at the monthly meetings. Restraint use is reviewed as part of the quality team meeting.

the monitoring and quality review of their use of restraint.		

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.

No data to display

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 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Bupa quality and risk management systems are being implemented at Beachaven. The framework ensures services adhere to the health and disability services standards. There are required actions being implemented when outcomes do not meet targets. Corrective action plans are implemented closed out and staff are involved in quality initiatives. Bupa has a strong focus on clinical benchmarking, both nationally and internationally. External training is supported, with evidence of attendance in staff files reviewed, verified through staff interview. ‘Tool box’ sessions, which are focused discussions with staff following for example a particular incident, are also seen to be provided regularly at Beachaven. All care givers are required to complete foundations level two as part of orientation. There are implemented competencies for care givers, enrolled nurses and registered nurses. Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s).	Bupa has robust quality and risk framework that is being implemented at Beachaven. The framework includes standardised policies; an education programme including core competencies for different staff groups; an internal audit and corrective action planning process; benchmarking against similar services types; centralised management of complaints and internal investigation following category one incidents; and surveys (resident/relative and staff). There is a prescribed meeting schedule for services that is also seen to be implemented at Beachaven.

			The annual education programme prescribed for the organisation is being implemented at Beachaven. Where attendance at a prescribed in-service is below expected either a 'tool box' session or additional in-service is provided. Tool box sessions are a regular part of Beachaven practice and are held in response to either an issue or a planned improvement. Examples of tool box talks include: introducing a resident, early stroke management, norovirus prevention, preventing urinary tract infections, ileostomy care and preventing bruising (as part of a quality initiative currently underway). Bupa prescribe competency assessments for different staff types such as RN, care givers; and these are current at Beachaven. In order to ensure competency assessments remain current a spread sheet is maintained by the care home manager and clinical manager. Beachaven supports staff to attend external training. From an organisational perspective, Bupa provides a bi-monthly clinical newsletter called Bupa Nurse providing forum to explore clinical issues and updates with all qualified nurses in the company and the Bupa geriatrician provides newsletters to GPs. Bupa's internal audit programme continues to be implemented at Beachaven. Where an internal audit result in less than 100% a corrective action plan has consistently been

			developed and closed out. Internal audits are delegated to various staff to encourage participation in a quality improvement programme. Clinical file review is part of the audit programme and interview with staff confirm they are involved in corrective actions when improvements are required. Services are benchmarked by service type, with Beachaven being benchmarked against psychogeriatric and hospital care. Corrective action plans are developed when rates exceed expectation, of note is the current focus on reducing the incidence of bruising. Areas of improvement successfully completed in 2014 include a reduction in staff injury following residents behaviours and a reduction in medication errors (refer 1.2.3.6). Meetings are held regularly and minutes reviewed include discussion about key aspects of care delivery and emerging trends resulting from benchmarking. Data is graphed and available in the staff room. Corrective action planning results where trends are above a target, and there is evidence of a reduction in resident incidents results (also refer 1.2.3.6). Outstanding matters are seen to have been followed through to the next meeting. Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of

			a resident(s). Of the 53 care staff at Beachaven, 31% have achieved bronze, 14% have achieved silver and 45% have achieved gold. Bupa undertake an annual staff survey – Global People Survey (GPS). Comparison between the 2013 and 2014 results indicate staff are happy with their work environment and are well supported by the care home manager and clinical manager. 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 meetings
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Quality improvement data has been collated monthly and reported to head office. Monthly data included clinical indicators such as skin tears, falls, medication errors, bruising, resident behaviours, and restraint and pressure injuries. Complaint activity, internal audit outcomes and CAP activity has also been reported. There is a prescribed meeting schedule that was being implemented at Beachaven that includes one - two monthly quality meetings, unit staff meetings, combined staff meetings, health and safety and infection control. Key components of the quality system have been discussed. Annual quality goals have been developed for each area of service including kitchen, activities, infection control, maintenance, clinical management, health and safety and physiotherapy. Monthly clinical indicator data has been collated across the facility monitoring hospital and psychogeriatric services. There is evidence of trending of clinical data, and development of CAPs when volumes exceed targets – e.g. bruising. There are falls prevention strategies are in place that include, hi/lo beds, on-going 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. Beachaven was focusing on reducing the rate of	Quality improvement initiatives for 2014 were identified through resident and relative survey, incident and accident reporting, staff incidents and through benchmarking data. Initiatives included: a) Reducing the incidence of staff injury following resident's behaviours by 30%. The rate of staff injury following resident's aggressive and resistive behaviours was noted to be above the acceptable limit. A working group was established to identify ways of reducing staff injury. The service developed a team of staff as champions of behaviour management to support and educate fellow staff members in keeping themselves safe

		bruising by 30% for the 2015 year. Actions include an analysis of 2014 incidents, development of an investigation sheet to attach to the incident form, inclusion of physiotherapist in the education programme for safe manual handling, and education sessions for staff re reducing bruising incidents- of which 51 staff attended. Month by month progress is being tracked. Quality Action Forms (QAF) are implemented in response to a facility quality initiative. The service was able to evidence that improvements have been made in response to quality initiatives. There is a health and safety, and risk management programme being implemented at Beachaven. The health and safety committee met 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.	and preventing and de-escalating resident's behaviours. The group are skilled in behaviour management an assist staff and review incidence of staff injury at their meetings. The incidence of staff injury related to resident behaviours reduced by 40% in 2014 with 21 incidences reported as opposed to 35 incidences in 2013. b) The service developed a 'resident of the day' programme whereby each resident is pampered and treated to a special lunch with invited family and friends. The meals for lunch and dinner are served on a tray and special food that the resident likes is provided. All staff including laundry and kitchen are aware of the resident's pamper day and each department is responsible for making the day as special as possible. This has been well received by residents, families and staff. c) Medication errors in the hospital have been reduced during 2014. This is in response to medication error incident reports. Education and training have been provided to support staff and to reduce the rate of errors. The rate of errors for 2013 was 40, the rate for 2014 was 27.
Criterion 1.2.3.7 A process to measure	CI	The service plans and operational structures combine to provide a comprehensive quality development and risk management system. Reports are provided to the quality meeting by key staff including; health and safety rep, infection control rep, activities, kitchen, education, laundry, clinical and restraint. Monthly benchmarking occurs throughout the group. Clinical and non-clinical	The Bupa quality and risk management programme continues to be implemented and measured so that improvements are made. They routinely review data from audits /

achievement against the quality and risk management plan is implemented.		indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Beachaven to document actions that have improved or enhanced a current process or system or actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, for example, quality meeting, and through newsletters. Progress to meeting quality goals is evaluated quarterly and annually.	complaints / A&Is at relevant meetings and in addition at meetings held by the focus groups. The service continues to focus on quality improvements. This has resulted in winning Bupa facility of the year in 2013/14 and again in 2014/15. They have won several quality poster awards depicting the various quality initiatives they have implemented. In 2014 their resident satisfaction survey had a 99% return rate and their net promoter's score of 89% was the highest in Bupa. A garden beautification programme has been implemented. A project to plant a fruit tree or vine for each resident (99) is still underway with 55+ currently planted. Other initiatives introduced (as a result of feedback) includes (but not limited); (i) all caregivers are learning to study a residents profile and 'present' the resident to their peers as part of "Getting to know you". Caregivers reported this has been positive and interesting. (ii) The Bupa PDRP project where all registered nurses ate encouraged to complete. The clinical manager is the driver of the programme and Beachaven has the most qualified staff that have completed the PDRP across the Bupa Group. Beachaven has several focus groups. These have been running for a number of years. Interviews and quality data analysed identified that these groups have made a difference. There is a

			'People on the Move' group that focuses on good manual handling to minimise bruises, skin tears and staff injuries. There is a 'Hit squad', a group monitoring injury to staff by residents to see if strategies can be put in place to prevent repetition. An evaluation of the effectiveness of the hit squad was completed and identified that staff / resident Behaviour incidents have decreased. The goal to reduce these incidents by 30% to 22 was met. In 2014, they had a Medication Error Management (MEM) committee to monitor and address medication errors (2014 goal). In 2015, a 'black and blue' committee has been established to endeavour to manage and prevent bruising.

End of the report.