

Bupa Care Services NZ Limited - NorthHaven 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:	NorthHaven Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 4 May 2015 End date: 5 May 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:	83



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
Yellow	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
Red	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

Northhaven Hospital is part of the Bupa group. The service is certified to provide rest home, hospital and psychogeriatric level care for up to 106 residents. On the day of the audit there were 83 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

Northhaven is managed by a care home manager who is appropriately qualified and experienced. There are quality systems and processes being implemented. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided.

The service exceeds the required standard around service goals and planning, response to incident trends and use of surveillance data. An improvement is required around aspects of nursing interventions.

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.
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Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is celebrated. Evidence-based practice is evident, promoting and encouraging good practice. 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

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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and acting clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. 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. Ongoing education and training for staff is in place.

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

The residents' files are appropriate to the service type and are compliant with all legislative requirements.

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.
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Residents and families receive comprehensive information on all services provided at Northhaven. The registered nurses are responsible for each stage of service provision. The assessments, care plans and evaluations are completed within the required timeframes. Residents and families interviewed confirm they participate in the care planning process. The general practitioners review residents at least three monthly.

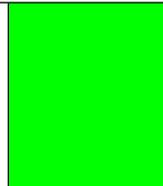
The activity programme is varied and appropriate to the level of abilities of the residents. Community links are maintained. Entertainment and outings are provided.

Medications are managed, stored, and administered in line with medication requirements. Medication training and competencies are completed by all staff responsible for administering medicines. Medication charts evidence three monthly reviews.

Food is prepared on site with individual food preferences and dietary requirements assessed by the registered nurses. Alternative choices are offered for dislikes. There are nutritious snacks available 24 hours.

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.

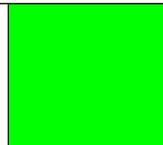


Standards applicable to this service fully attained.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building has a current warrant of fitness. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised with access to shared ensuite or communal facilities.

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.

Enablers are voluntary and the least restrictive option. There were 12 residents with restraints and two residents who required enablers during the audit. Appropriate assessments, care planning, monitoring and evaluations are in place around restraint and enabler use. Environmental restraint is in use.

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.

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	47	0	1	0	0	0
Criteria	3	97	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with all four caregivers, eight registered nurses, the acting clinical manager and the care home manager and four activities staff reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Informed consent and advanced directives were recorded as evidenced in the 10 resident files reviewed (one rest home, five hospital and four psychogeriatric). Family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the HDC Office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. The orientation coordinator also undertakes a role as resident advocate. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. This includes resident's visits to the local mall, visiting the library and attending community celebrations. Resident/family meetings are held quarterly.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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 facility 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.</p> <p>Discussions with the residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are in a visible location at the entrance to the facility. Five complaints received in 2015 were reviewed with evidence of appropriate follow-up actions taken.</p> <p>ARHSS D13.3g: The complaints procedure is provided to relatives on admission.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The clinical manager/registered nurse (RN) discusses aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the quarterly resident/family meetings. All ten residents (three rest home level and seven hospital level) and 13 relatives (one rest home level, four psychogeriatric level and seven hospital level) interviewed report that the residents' rights are being upheld by the service. Interviews</p>

		<p>with residents and family also confirmed their understanding of the Code and its application to aged residential care.</p> <p>ARHSS D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service ensures that the residents' rights to privacy and dignity are recognised and respected at all times. The residents' personal belongings are used to decorate their rooms. All rooms are single rooms. Discussions of a private nature are held in the residents' rooms. The caregivers interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They report that they encourage the residents' independence by encouraging them to be as active as possible. All of the residents interviewed confirmed that their privacy is being respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Any suspected instances of abuse or neglect are dealt with in a prompt manner by the management team.</p> <p>ARHSS D4.1b Four psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. They value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. During this audit there were no Maori residents living at the facility.</p> <p>Maori consultation is available through the documented Iwi links and Maori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whanau in the delivery of care for Maori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>

<p>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>ARHSS D4.1d: Four care plans reviewed from the psychogeriatric unit included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p> <p>ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interview with one health care assistant from the psychogeriatric unit could describe how they build a supportive relationship with each resident. Interviews with four families from the psychogeriatric unit confirmed the staff assist to relieve anxiety.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A general practitioner (GP) visits the facility each working day. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the District Health Board which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site, eight hours per week. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>The GPs interviewed is satisfied with the level of care that is being provided.</p> <p>A number of quality improvements have been implemented/made including (but not limited to): (i) in 2014 the service met several aspects of the set quality, health and safety and Global people survey goals. (ii)There was an increase in resident satisfaction with an increase in return rates of surveys from 48 % in 2013 to 67% in 2014 and an increase in overall satisfaction from a high 84 % in 2013 to 88% in 2014. (iii)There were increases in resident / family feedback with 90% feeling staff took the time to get to know them, 89% feeling Northhaven had well trained staff, 84% finding activities to be meaningful and 93% feeling Northhaven provided a supportive homelike environment. (iv) 100% of the staff were enrolled on the Bupa BFIT programme in both</p>

		<p>2014 and in 2015 and staff survey rates demonstrated increase in satisfaction around areas of growth / support and development. (v) There was no use of restraint in the PG unit in 2014 and 2015 to date and a decrease in restraint use levels across hospital level care. (vi) In the PG unit there has been a decrease in agitated challenging behaviours with the use of a door disguise transfer to minimize agitation of residents wanting to leave the safe dementia environment; (vii) The service has created a dedicated palliative care room for residents at end of life and created daisy boxes that store items that may be required at end of life and can be easily used to improve quality of life at this time.</p> <p>Two senior staff has been nominated for leadership courses and the manager has been selected to attend a senior leadership programme. Northhaven have appointed an orientation facilitator into a supernumerary role to support both new and developing existing staff .They have also appointed two staff as room staging champions to assist in creating a more homely feel in both the general environment and resident's room areas.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>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.</p> <p>Evidence of communication with family/whanau is recorded on the family/whanau communication record, which is held in 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. Twelve accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>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.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. 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.</p> <p>ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to the psychogeriatric unit booklet providing information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.</p>
Standard 1.2.1:	CI	<p>Northhaven is a Bupa residential care facility. The service currently provides care for up to 106 residents at hospital, rest home, and psychogeriatric levels of care. On the day of the audit there were 58 hospital level</p>

<p>Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>residents, 20 residents in the psychogeriatric unit and five rest home residents. Three residents were under the age of 65 on long term chronic needs contracts.</p> <p>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.</p> <p>The care home manager is a registered nurse with a current practising certificate who has 20 years of experience of management in the health sector, including in aged care. She has been in this role since 2013. She is supported by an acting clinical manager/RN who is employed as clinical manager at another Bupa facility and an operations manager. The position of clinical manager is being actively recruited for.</p> <p>The care home manager and operations manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p> <p>The service exceeds the standard around governance and service goals.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The manager is supported by a clinical manager/registered nurse (RN) (currently acting) who is employed full time and steps in when the manager is absent. She has experience as clinical manager at a Bupa facility for the past four years.</p> <p>ARHSS D4.1a: The service operational plans, policies and procedures promotes a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	FA	<p>A quality and risk management programme in place. Interviews with the managers and staff reflect their understanding of the quality and risk management systems that have been put into place.</p> <p>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. 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, 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.</p>

improvement principles.		<p>Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The organisation holds tertiary accreditation by ACC for their workplace safety management programme.</p> <p>ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>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. Fourteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. The service exceeds the standard around response to incident rates.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eleven staff files sampled 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. The service has a designated orientation coordinator to support new and existing staff.</p> <p>A register of practising certificates is maintained.</p> <p>There is an annual education and training schedule that is being implemented. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the District Health Board.</p> <p>ARHSS D17.1: There are 29 healthcare assistants in the psychogeriatric unit. Twenty-six of these have completed the required dementia standards and the other three have been at the service less than six months and are currently enrolled in the programme.</p> <p>ARHSS D17.7: The activity coordinator working in the psychogeriatric unit has completed dementia modules. Two of the three activities officers have completed the dementia standards and the third has recently</p>

		commenced employment.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing levels meet contractual requirements. The facility manager and acting 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 healthcare assistants. Interviews with the residents and relatives confirmed staffing overall was satisfactory. There are five RNs across morning and afternoon shift and two at night. RNs rostered include an RN in the PG unit across 24/7.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have needs assessment completed prior to entry that identifies the level of care required. The acting clinical manager (CM) screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents and relatives stated that they received sufficient information on admission and discussion was held regarding the admission agreement. There is a well-developed information pack, which includes advocacy and health and disability information. A handbook on dementia care is included in the information pack for families whose relative is being admitted to the psychogeriatric unit.</p> <p>D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract. D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility. D14.1 Exclusions from the service are included in the admission agreement. D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follows up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are current. One self-medicating resident has been assessed and reviewed as per policy.</p> <p>All 20 medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. Anti-psychotic management plans are used for residents with dementia when medications are commenced, discontinued or changed. The psychogeriatrician reviews the management plans at least monthly or earlier if required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Bupa Northhaven are prepared and cooked on site. There is a six weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered in scan boxes to each units dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks in the psychogeriatric unit. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfaction with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier.</p> <p>ARHSS D15.2f: There is evidence that there are additional nutritious snacks available over 24 hours.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The reason for declining service entry to residents should this occur is communicated to the resident or family/whanau and they are referred to the original referral agent for further information.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments are available for use as applicable. Risk assessments were completed on admission and reviewed six monthly in the resident files sampled. Risk assessment tools are used to identify the required needs and interventions required to meet resident goals.</p> <p>ARHSS D16.5gii: Four resident files sampled included an individual assessment that included identifying diversionary, motivation and recreational requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident focused care plans (My Day, my way) describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>D16.3k: Short term care plans were in use for changes in health status.</p> <p>D16.3f: There is documented evidence of resident/family/whanau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</p> <p>ARHSS 16.3g: Four resident files reviewed from the psychogeriatric unit identified current abilities, level of independence, identified needs and specific behavioural management strategies. All files had comprehensive behaviour management plans (specific dementia needs).</p>
<p>Standard 1.3.6: Service</p>	PA Low	<p>A written record of each resident's progress is documented. Resident changes in condition are followed up by a registered nurse as evidenced in residents' progress notes. When a resident's condition alters, the registered</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff stated they have all the equipment referred to in care plans necessary to provide care.</p> <p>Dressing supplies are available and a treatment rooms were well stocked for use. Wound initial assessment plans and wound evaluations were completed for nine skin tears and four hospital residents with pressure areas (two grade 2 and two grade 3). There has been wound nurse specialist and GP involvement in the care of pressure areas.</p> <p>Continence products are available and specialist continence advice is available as needed. A physiotherapist is employed to assess and assist resident's mobility and transfer needs.</p> <p>There is an improvement required around implementation of interventions to meet the resident's current needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>There is a qualified diversional therapist that oversees the activities in each area (two hospital units and one psychogeriatric unit). There are three activity assistants (two with dementia standards) who provide a five day week separate programme in each of the areas. Hospital activity assistants rotate weekly between the units.</p> <p>The programme offers variety and interest with entertainment and outings. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. Some activities are integrated such as special events, entertainment and church services. Community links are maintained. One on one time is spent with residents who are unable or choose not to participate in group activities</p> <p>Activity assessments were completed on admission in the resident files sampled. Activity plans and care plans are reviewed at the same time.</p> <p>ARHSS 16.5g.iii: A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. The activity care plan and 24 hour MDT care plan is reviewed at least six monthly.</p> <p>ARHSS 16.5g.iv: Caregivers were observed at various times through the day diverting residents from behaviours. The activities observed were appropriate for older people with mental health conditions. The service has recently changed the activity programme from 10am to 4pm. Staff report this has had a positive effect on resident behaviours.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Initial care plans are evaluated within three weeks of admission. Long term care plans reviewed were evaluated by the registered nurses or when changes to care occur. A multi-disciplinary team meeting is conducted six monthly for each resident and involves all relevant personnel. The contracted GP examines the residents and reviews the medications at least three monthly. Short term care plans for short term needs were</p>

evaluated in a comprehensive and timely manner.		evaluated within a timely manner.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>D16.4c; The service provided evidence of re-assessments for higher level of care.</p> <p>D 20.1: Discussions with the clinical manager and registered nurses identified that the service has access to GPs, ambulance/ emergency services, allied health, dietitians, physiotherapy, continence and wound specialists.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Blood and chemical spills kit are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their</p>	FA	<p>The building has a current building warrant of fitness that expires on 22 February 2015. There is a full time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded fortnightly with corrective actions for temperatures outside of the acceptable range.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade.</p>

purpose.		<p>ARC D15.3: ARHSS D15.3e The caregivers and registered nurses state they have all the equipment required to provide the level of care documented in the care plans.</p> <p>ARHSS D15.3d: The psychogeriatric unit has an open plan lounge and dining area and external covered conservatory with seating where quieter activities or family visits can take place.</p> <p>ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.</p> <p>ARHSS D15.3b: There is a safe and secure outside area that is easy to access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are some shared ensuite and communal use in the hospital wings. There are communal toilets and showers in the psychogeriatric unit. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is a mix of shared and single rooms in the hospital wing and psychogeriatric unit. Privacy curtains are in place in double rooms. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalize their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>Communal areas within the facility include open plan lounge and dining area in each unit. There are smaller lounges and a family room within the facility. The communal areas are easily accessible for residents.</p> <p>ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and housekeeping staff seven days a week. Cleaning trolleys are kept in designated locked cupboards. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures are in place. An approved fire evacuation plan is in place. Fire evacuation drills take place every six months. The orientation programme and annual education and training programme includes mandatory fire and security training. Staff interviewed confirmed their understanding of emergency procedures.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one person who is available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p> <p>External lighting and security systems are adequate for safety and security.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	<p>FA</p>	<p>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Bupa has an established infection control (IC) programme that is implemented at Northhaven. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. A registered nurse is the designated infection control nurse with support from the acting clinical manager and other Bupa infection control coordinators. The IC team meets to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Northhaven. The relieving infection control (IC) nurse has maintained her practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually.</p>

are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control coordinator with support from the clinical manager. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there have been no recent outbreaks). Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014. The infection control coordinator completed on line Ministry of Health infection control training in December 2014.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<p>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. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Infection control data is collated monthly and reported at the facility meetings. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The service exceeds the standards around use of surveillance information to reduce infection rates.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The service has two residents with bedrails on the enabler register and 12 residents are on the restraint register including four who are environmentally restrained as they cannot use the keypad exit or read the code number written clearly at the keypad. All enabler use is voluntary.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator is the acting clinical manager. The restraint approval process and the conditions of restraint use are recorded on the restraint assessment form. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/ whanau. The multi-disciplinary team is involved in the assessment process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint assessment form is completed with input from the RN, and GP and the resident's family and this was documented in the four resident's files for residents who use restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Four files were reviewed for residents with restraint. The review identified clear instructions for use of 'bedrails or the lap belt, approval process, risks and monitoring requirements.</p> <p>Restraint intervention is fully described in the care plan with daily monitoring records completed by staff.</p> <p>The restraint register is in place and is updated monthly.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all</p>	FA	<p>Four files were reviewed of residents requiring restraint including environmental restraint. The use of restraint episodes are evaluated two monthly and documented; if a change occurs it is documented at the time. All episodes are also reviewed by the restraint coordinator six monthly.</p>

episodes of restraint.		
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The restraint coordinator is the acting clinical manager. The restraint committee at Northhaven includes clinical and non-clinical staff who meet two monthly to review restraint use. An annual audit is completed on restraint use.

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)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Short term care plans document the management of short term needs. Short term needs are evaluated and resolved or transferred to the long term plan if the problem is on-going.	(i) There were no weekly weigh or nutritional record for two residents (one rest home and one hospital) as per the short term care plans for weight loss. (ii) There were no documented interventions for one psychogeriatric resident with weight loss. (iii) The mobility transfer plan interventions for two residents (one psychogeriatric and one hospital) did not align with the interventions in the long term care plans.	<p>Ensure interventions are documented and implemented to meet the resident's current health status.</p> <p>90 days</p>

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
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. In 2009, Bupa introduced a person centred care focus which includes six pillars. This has been embedded in service delivery at Northhaven.</p> <p>There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan with goals for</p>	<p>Bupa has robust quality and risk management systems implemented at Northhaven. The Northhaven care home manager provides a documented weekly report to the Bupa operations manager. The operations manager visits regularly and completes a report to the general manager care homes. Northhaven is part of the North 1 Bupa region which includes ten facilities. The managers in the region including the Northhaven care home manager meet four monthly, senior managers mentor and provide guidance to new managers. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Northhaven and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. The 2015 goals have been broken down to mini goals that can be achieved in each quarter to culminate in meeting the annual goal. Progress toward mini goals is documented at every quality meeting. Northhaven's annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'.</p> <p>The 2014 goals for Northhaven were formally reviewed and reported on every quarter.</p>

		<p>the year for the service. This occurs in January each year at Northhaven. The Bupa CNS provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. There is an overall Bupa business plan and risk management plan.</p>	<p>The 2014 goals included having 95% of well trained staff as deemed by the resident/relative satisfaction survey. This was achieved by (but not limited to) all staff in the dementia unit having or working toward the dementia NZQA standards and all kitchen staff having food safety qualifications. Another goal was to deliver truly person centred care; ensuring residents have greater choice in their lifestyle choices at Northhaven. This was achieved using the personal best programme and over 90% of staff have completed bronze with over 30% having completed silver and gold. A personal best facilitator has been appointed and reports that management and staff are enthusiastic about improving resident's lives through the personal best initiative. A number of facility improvements are documented in response to the goal to ensure 95% of residents and family feel Northhaven provides a safe and homelike environment. 2015 goals documented include to gift the residents quality of life and excellence of care (the resident focussed goal), to create an environment where staff love working, feel happier and healthier for working at Northhaven and feel supported to shine and be the best they can be delivering their best each and every day (the staff focussed goal) and for the community to know and trust Northhaven (the community focussed goal. For each goal there are a number of aspects by which achievement of the goal will be measured and a variety of strategies to be implemented to meet the goal. The January to April 2014 quality meeting minutes document positive progress toward meeting the goals.</p>
<p>Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for</p>	<p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and qualified staff meeting reflect a discussion of benchmarking results. The incident/infection analysis tool and quality indicator corrective action plan is well utilised at Northhaven to assist with analysis and plan improvements to service delivery. There are a number of initiatives that have been implemented across 2014 - 2015 when benchmarking results are above the normal. For example in response to the falls rate having been above the benchmark for a period in 2014 a falls reduction programme was undertaken. This included individual falls being tracked and logged on an A3 size analysis sheet as they occur rather than at the end of the month so all staff can be involved in being proactive and looking at triggers, commencing intentional rounding to reduce falls occurring due to unmet needs, the GP reviewing and rationalising medications for frequent fallers, completing a lying and standing blood pressure for all residents who fall to ascertain if postural drop caused the fall and</p>

		comparative purposes. Minutes of the quality meetings, staff meetings and peer review meeting reflect a discussion of benchmarking results.	implementing the use of non-slip socks for appropriate residents. Additionally falls awareness posters were placed around the facility as a staff reminder and traffic on bedroom walls indicate how many people are needed to support a resident mobilising. This has resulted in a significant reduction in falls (below the benchmark) in 2015 to date. In response to analysis of challenging behaviour incidents in the psychogeriatric unit it was identified that several incidents happened near the door with residents trying to leave. The service sourced a large picture decal to disguise the door and this has resulted in a reduction in this type of incidents.
<p>Criterion 3.5.7</p> <p>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.</p>	CI	<p>Infection control (IC) data is collated monthly and reported to the quality and infection control meetings. 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, food service, and environmental cleanliness.</p>	<p>The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC statistics are discussed at registered nurse meetings and corrective actions are implemented when infections increase. Incident/infection - analysis tool is utilised to assist with identifying trends. In January 2015 the service was above the Bupa benchmark for urinary tract infections. A quality indicator corrective action plan was developed and interventions included offering additional cool drinks during intentional rounding, offering ice blocks on the afternoon shift in warmer weather, using air conditioning to keep the air temperature appropriate to reduce perspiring, offering jelly on afternoon tea rounds and using tool box talks to remind care staff of personal hygiene and genital cares. The evaluation of this plan showed that while the urinary tract infection rate had dropped the rate was still above the benchmark in February 2015. A further quality indicator corrective action plan was developed that included education for registered nurses around infection criteria to ensure that all reported infections meet the listed criteria as it had been identified that not all reported infections met the criteria, implementing additional drinks rounds in hotter weather and random audits and reviews by the clinical manager and unit coordinators to ensure all care staff were following best practice. The urinary tract infection was below the benchmark for March 2015 and a review of reported infections for April (not yet benchmarked) indicates the urinary tract infection rate has dropped further.</p>

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End of the report.