# Bupa Care Services NZ Limited - The Gardens Rest Home and Hospital

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

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

The specifics of this audit included:

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

**Premises audited:** The Gardens Rest Home and Hospital

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

**Dates of audit:** Start date: 11 May 2015 End date: 11 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:** 51

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Bupa The Gardens Rest Home and Hospital provides rest home and hospital care for up to 54 residents. On the day of audit there were 51 residents. The service is managed by a care home manager and is supported by a clinical manager. The residents and relatives interviewed all spoke positively about the care and support provided.

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

The service has addressed one of five findings from their previous certification audit in relation to wound care documentation. Further improvements are required in relation to incident documentation follow through, care plan timeframes, care planning interventions and aspects of medication documentation. This audit has identified improvements required around maintaining a complaints register, the quality programme and aspects of human resources, and assessments.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants.

## Organisational management

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

The Bupa strategic and quality plan is being implemented with new quality goals developed for 2015. Corrective actions are identified following internal audits. Quality meeting and other facility meetings are held. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place to determine staffing levels and skill mixes. Staffing levels meet contractual requirements.

## Continuum of service delivery

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

The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. Care plans demonstrate service integration. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice. The activities programme is facilitated by an activities co-ordinator and two activity assistants. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular and resident rotational basis.

All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

## Safe and appropriate environment

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

The building has a current warrant of fitness that expires 13 January 2016.

## Restraint minimisation and safe practice

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is currently one resident requiring restraint and one resident using an enabler. Staff are trained in restraint minimisation and challenging behaviour.

## Infection prevention and control

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

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 10 | 0 | 3 | 5 | 0 | 0 |
| **Criteria** | 0 | 30 | 0 | 5 | 7 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The organisational complaints policy is implemented at The Gardens. The care home manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. A feedback form was completed for each complaint recorded on the complaints register in 2014. There is a complaints register maintained for 2014 that included relevant information regarding the complaint. Documentation including follow up letters and resolution were available. Verbal complaints were included and actions and response documented. There were three complaints received in 2014. All complaints were fully documented with follow up letters and resolution. There was no complaints register available for 2015. The number of complaints received each month is reported monthly to staff via the various meetings. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. A complaints procedure is provided to residents within the information pack at entry. The complaints procedure is provided to relatives on admission and this was confirmed through interview with relatives. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Seven residents (six rest home and one hospital) and six family members (two rest home and four hospital) interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incident reports for April 2015 indicated family were notified of resident’s incidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings take place and the care home manager, clinical manager and registered nurses have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English then the interpreter services are made available. All residents were English speaking on the day of the audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Gardens is a Bupa facility. The service provides rest home and hospital level care for up to 54 residents. There were 51 residents (25 rest home including two respite and 26 hospital including one respite, three young persons with disability and one resident on an ACC contract) in the facility on the day of audit.  There is a contracted physiotherapist that provides 8 hours a week. There are fifteen GPs that provide general practitioner services. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. The Gardens’ developed objectives for 2014. New goals have been set as documented in the quality meeting February 2015 including all residents to be entered on InterRAI by the end of the year and that 80% of staff to be enrolled in dementia training.  The care home manager at The Gardens has been in the role since December 2014. The care home manager was previously the assistant manager at another Bupa facility for 1 and a half years. The care home manager was not present on the day of the audit. The manager from a sister Bupa facility and the clinical manager were present on the day of the audit. The care home manager is supported by a clinical manager (registered nurse) who oversees clinical care. The clinical manager had been in post for three years (has been at the service for six years as a registered nurse) and provides peer support and supervision to the registered nurses and caregivers. The management team is supported by the wider Bupa management team including a regional operations manager. The care home manager and clinical manager have maintained professional development related to managing a hospital facility. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six month. |
| 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. | PA Low | There is a Bupa strategic plan for 2015 and a quality and risk management plan for Bupa The Gardens. Overall Bupa is working towards 2020 goals including (but not limited to), having staff love working for Bupa and increasing ability to meet people needs “health care partner to millions more”. Goals and objectives relate to building strong and connected communities, provide leadership within the sector, and maximise resource to deliver on the BUPA mission.  The quality plan for 2015 has been developed. Quality improvement initiatives for The Gardens have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents during 2014. The Gardens is part of the Bupa benchmarking programme with feedback provided monthly around a set of clinical indicators. A report, summary and areas for improvement are received. Progress with the quality assurance and risk management programme is monitored through the Bupa regional meetings, and the various facility meetings. Monthly and annual reviews are completed for all areas of service. Overall meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for 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.  There is an internal audit schedule which has been completed for 2014 and a schedule in place for 2015. Not all audits have been completed as per the 2015 schedule. Areas of non-compliance identified through quality activities are documented as corrective actions, however there is not clear evidence that all corrective actions have been implemented or signed off and reviewed for effectiveness.  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. The service has comprehensive policies/ procedures to support service delivery. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents (link 1.2.4.3 and 1.3.4.2) and staff receive training to support falls prevention. 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 their family/whānau of choice in an open manner. | PA Moderate | Incident and accident data is collected and analysed and benchmarked through the Bupa benchmarking programme (# link 1.2.3.8). Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for April 2015 were reviewed (three rest home and three hospital residents’ incidents reports). Two rest home and two hospital incidents reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident. Reports were completed and family notified as appropriate. Incidents and accident data is communicated to staff as evidenced at staff interview and meeting minutes. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The previous audit finding around assessments and follow up management still requires further improvement. |
| 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. | PA Low | The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (three caregivers, one cook, two registered nurses and one clinical manager). 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. Six of seven staff files reviewed had evidence of orientation completed. The clinical manager reports staff turnover is low and a number of staff have been at the service for over 20 years. Annual appraisals are expected to be conducted for all staff. There is a completed in-service calendar for 2014 which exceeds eight hours annually and a schedule for 2015 including annual competencies. Caregivers (80%) have completed Bupa foundations skills and either the national certificate in care of the elderly or have completed or commenced Careerforce. The care home manager, clinical 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 | Bupa The Gardens has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse on duty at all times. The clinical manager works full time. The clinical manager is available on call for all clinical matters. The clinical manager manages the facility when the care home manager is away. There was sufficient staff observed to assist residents in the dining rooms with meals including activities staff. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Bupa has comprehensive medication policies in place. There are currently 15 GPs attending to residents’ at The Garden’s from different medical centres.  Medication storage follows safe guidelines. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on admission. Medication competencies have not been completed annually for all staff administrating medications.  Fifteen medication charts were reviewed (seven rest home and eight hospital level). Weekly medication checks documented. There are shortfalls identified around medication documentation. An improvement continues to be required around signing of medication. |
| 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 national menus have been audited and approved by an external dietitian. The service employs a kitchen manager and kitchen assistants. Fridge and freezer temperatures are monitored and documented daily in the kitchen. All food containers are labelled in kitchen. Meals are prepared in the kitchen and delivered to the dining room.  There are nutritional assessments and management policy and a weight management policy.  The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes and dislikes. This is reviewed six monthly as part of the care plan review and communicated to the kitchen. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets are catered for. Residents’ interviewed stated that the food service was satisfactory. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | All residents are admitted with a care needs level assessment completed by the needs assessment and service co-ordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Overall, assessments were reviewed at least six monthly, or more as condition changes (# link 1.2.4.3). There was no assessment completed for one resident with challenging behaviour and risk assessments were not current for one hospital resident. One registered nurse (RN) had completed InterRAI training and the assessment tool was evident in some resident files. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | One rest home respite (one of six files sampled) and a hospital residents file reviewed with bedrail restraint did not have full and comprehensive care plans completed to direct staff with resident care. Long-term care plans reviewed overall included the resident’s problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that included short-term cares. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition changes, the registered nurses initiate a review and if required, GP or specialist consultation.  The caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. All staff report that there are always adequate continence supplies and dressing supplies. Residents and families interviewed were complimentary of care received at the facility.  The care being provided is consistent with the needs of residents; this is evidenced by discussions with caregivers, families interviewed, two registered nurses and clinical manager (link 1.3.5.2). There are short-term care plans that are used for acute or short-term changes in health status.  Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans were in place for eight residents. There were two pressure areas identified in the service (one facility-acquired). Wound assessments have been completed. Short term care plans for wounds describe appropriate interventions. All wounds have been reviewed in the timeframes. Aspects of wound care documentation, was a previous audit finding that has now been addressed. |
| 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 an activity co-ordinator who is contracted to work 37 hours a week, however, is currently working two hours a day, due to a ‘return to work programme’ following an accident. There are also currently two other activity assistants, one works three days a week (0900 – 1500) and the other two days a week (0900-1600).  There is a full and varied activities programme in place, which is appropriate to the level of participation from residents’. On the day of audit residents in both areas were observed being actively involved with a variety of activities. The programme is developed monthly, with weekly updates, and displayed in large print in communal areas and resident bedrooms. There are regular van outings and there is a roster, so all residents have an opportunity to go out. Most residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met. However, one family member commented about the music on the television always being on for hospital residents’.  Residents have an activities assessment completed over the first few weeks. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Review and evaluating of care plans by an RN, at least six monthly, or as changes to care occur is not always completed in a timely manner (# link 1.3.3.3). All initial care plans reviewed were evaluated by the RN within three weeks of admission. There is documentation evidence of family and/or resident involvement at these evaluations. Documentation on clinical notes evidence review by the GP at least three monthly.  A sample of resident files short-term care plans identified clear interventions directing staff in resident care. There are short-term care plans to focus on acute and short-term issues. This is an improvement since the previous audit. From the sample group of residents' notes the short-term care plans were overall well used and comprehensive. Examples of short-term plan use included; infections, wounds and weight loss. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness that expires 13 January 2016. |
| 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 | Infection surveillance and monitoring is an integral part of the infection control programme and is described in Bupa’s infection prevention and control policy. Systems in place are appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections based on signs and symptoms of infection. The infection control coordinator (RN) has been in the role for three years and has maintained IC training. 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. There are monthly IC meetings (# link 1.2.3.1). 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. There is close liaison with the GP's that advise and provide feedback /information to the service. There have been no outbreaks at the service over the last two years. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregivers and nursing staff confirm their understanding of restraints and enablers. Training has been provided around restraint, enablers and challenging behaviours. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings (# link 1.2.3.1) and at an organisational level. There is one hospital resident currently with bedrail restraint (# link 1.3.5.2) and one hospital resident using bedrail enablers. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | In 2014, a complaints register has been maintained with all complaints and actions taken through to resolution including three complaints identified during 2014. | There is no register available for 2015, however the quality meeting minutes reviewed in 2015 document no complaints received. | Ensure that a complaints register is maintained to give clear indication of monthly complaints.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | Bupa has an annual audit schedule to be implemented for measurement of achievement of quality and risk management of services. This was evident and up to date in 2014. | Not all audits have been completed as per the Bupa schedule 2015 including multi-disciplinary team audit review (February), environmental nursing hygiene (March) and clinical file audit (April). The monthly quality meeting minutes have not been updated to reflect audits completed in 2015. | Ensure that all audits are completed as per the audit schedule to measure achievement against the quality and risk programme. Ensure internal audit feedback is documented in meeting minutes.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | (i) The service conducts audits and has completed corrective action plans which were signed off as completed including but not limited to activities programme (July 2014), medication management (August 2014), and MDT review (August 2014). (ii) The service collates incidents and accident data and infection data and benchmarks with other Bupa facilities. “Red flag” areas require corrective action plans to address areas above the benchmark (KPIs). | (i) Not all audits where there has been areas requiring improvement have corrective action plans developed and signed off as completed including (but not limited to) clinical file audit (October 2014), care planning (November 2014), medication management (February 2015) and cleaning audit (March 2015). (ii) Red flag areas of incidents including falls consistently above the bench mark indicators in 2015 for rest home and hospital do not have corrective action plans developed and implemented to address these areas. | (i)& (ii) Ensure that all areas that require improvement from audits or benchmarking have corrective action plans developed and implemented.  90 days |
| 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. | PA Moderate | Incident and accident data is collected and analysed and benchmarked through the Bupa benchmarking programme. A sample of resident related incident reports for April 2015 were reviewed. Three rest home and three hospital residents’ incidents reports were reviewed. Two rest home and two hospital incidents reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. | (i)One rest home resident had four falls during April 2015. The residents care plan and falls risk assessment had not been updated since May 2014 and the falls risk states the resident is at low risk of falls. (ii) One hospital resident had nine falls during April 2015. The residents care plan reviewed in May 2015 states there has been no changes to mobility and there is no update to indicate frequent falls. Falls risk assessments have been completed six monthly (last six monthly assessments 6 May 2015). | Ensure that adverse events identified have risk assessments completed in a timely manner and care plans updated so as to reflect the risks and direct staff in residents care.  30 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Annual appraisals are expected to be conducted for all staff. One of seven staff files reviewed was not due for a performance appraisal. The service completes annual competencies including but not limited to assessments tools, restraint, moving and handling, nebulisers, oxygen administration and blood sugar testing. | (i) Six of seven staff files reviewed did not have evidence that annual performance reviews had been completed. Two had no reviews completed, one last completed in August 2013, one last completed in November 2013 and two last completed in December 2013. One staff member was not due for a review. (ii) Annual competencies were overdue for staff including (but not limited to) moving and handling (seven staff) and restraint (three staff). | (i)Ensure that all staff have an annual performance appraisal. (ii) Ensure that annual competencies are completed.  90 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice as evidenced in six of seven files reviewed. | One caregiver employed in July 2014 has no documented evidence of orientation/induction being completed. | Ensure there is documented evidence that all staff complete orientation/induction to cover all aspects of service provided and ensure safety of staff and residents.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | There are established BUPA policies and procedures around safe medication management and administration. Signing on administration was up to date, including as required medications (PRN). There was one medication signing sheet which had evidence of transcribing. A previous audit finding around signing for non-packaged medication still requires improvement. | (i) One medication signing sheet for a respite resident had evidence of transcribing. (ii) One resident prescribed topical non-packaged medication was not being signed for when administered. | (i) Ensure that medication dose, strength, frequency is not written on the top of the signing sheet by non-prescribing officers. (ii) Ensure all prescribed non-packaged medication is signed for when administered.  60 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Staff that administer medication have competency assessments completed annually. A register of medication competency staff is maintained. | Two registered nurses and one enrolled nurse that administer medications do not have a current medication competency completed. | Ensure that all staff administering medications have an annual medication competency completed.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Of the 15 medication charts sampled, five did not have photographic identification. Not all PRN medications had indication for use identified on the medication chart. This was a previous audit finding that still requires improvement.  Identification of resident allergies on the medication charts is an area for improvement.  Fifteen medication charts reviewed had written evidence of the GP three monthly review, or more as conditions changed, all had been signed and dated. | (i) Five of fifteen medication charts did not include a resident photograph. (ii) Five of fifteen medication charts did not identify resident allergies. (iii) Five of fifteen medication charts reviewed did not include indication for use for, as required medication (PRN). | (i) Ensure the GP/pharmacy include allergies on the medication chart. (ii) Ensure that all medication charts include a resident photograph for identification. (iii) Ensure that the GP or pharmacy include indication for use for all PRN medications on the medication chart.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Six resident care plans were reviewed; three rest home (including one respite) and three hospital level. Six assessments and initial care plans were completed within 24 hours of admission. The remaining sections of nursing documentation were completed within 21 days. Three of five long term care plans were evaluated at six months or as needed as resident condition changes. This was a previous audit finding that still requires improvement. Six resident files reviewed identified that the general practitioner (GP) had seen the resident within two working days. This was a previous audit finding that has now been addressed. | Three residents care plans (one rest home and two hospital) were not evaluated six monthly. | Ensure that all residents’ care plans are evaluated at least six monthly or when resident needs change.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Bupa has policies around identifying, through the assessment process, the required needs, outcomes and goals of the resident. | One rest home resident identified as presenting challenging behaviour did not have a challenging behaviour assessment in place. One hospital resident did not have up to date assessments completed around pain, continence, falls risk, pressure area risk, and nutrition in their resident file. | Ensure that all residents have up to date assessments completed in the resident files, which are reviewed six monthly, or as condition changes.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | BUPA have policies around identifying care planning in a timely manner and the need to reflect the resident’s needs. Five of six long-term care plans reviewed included the resident’s problem/need, objectives, interventions and evaluation for identified issues. | (i) One respite resident has a care plan with another resident’s name identification throughout. (ii) One hospital resident identified as using bedrail restraint has been at the service since August 2014 and does not have a full and comprehensive care plan completed. The care plan only details interventions to support personal care and eating and drinking. There were no interventions to support the use of restraint and direct staff in safe management and care of the resident. The residents care plan and risk assessments have not been reviewed since admission. The service was addressing these issues immediately. | Ensure that each resident has a full and comprehensive care plan that is reviewed / evaluated, reflects the assessed needs of that resident and directs the staff in the care of that resident.  60 days |

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

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

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

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

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End of the report.