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

## Introduction

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

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

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

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

The specifics of this audit included:

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

**Premises audited:** Broadview Rest Home & Hospital

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

**Dates of audit:** Start date: 8 June 2015 End date: 9 June 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:** 72

# 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

Broadview Rest Home & Hospital is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), dementia, mental health hospital and psychogeriatric level care for up to 85 residents. On the day of the audit there were 72 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.

Broadview is managed by a care home manager who is appropriately qualified and experienced. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided.

Improvements are required around meeting minutes, staff training including the infection control coordinator, storage of chemicals, nursing interventions, care plans, review of plans and medication fridge temperatures.

## 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. |

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

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

An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. The service also runs a focus group for supporting families and residents in the Kauri mental health unit.

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

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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. |

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included medical notes by the contracted GP, psychogeriatrician and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

A diversional therapist oversees the activity team and coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

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

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. 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 ensuites or communal facilities. 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.

## Restraint minimisation and safe practice

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

Enablers are voluntary and the least restrictive option. There were 12 residents with restraints and one resident who required an enabler 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

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

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** | 0 | 46 | 0 | 6 | 1 | 0 | 0 |
| **Criteria** | 0 | 117 | 0 | 6 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | 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 six registered nurses (two mental health and psychogeriatric services ,one dementia and rest home and five hospital), ten caregivers, (three mental health and psychogeriatric services ,two dementia, three rest home and two hospital,) one activities co-ordinator, the clinical manager and the care home manager reflected their understanding of the key principles of the Code.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in 10 if 10 resident files sampled (two rest home, two hospital, two dementia, two mental health and two psychogeriatric). Advance directives if known were on the resident files. Resuscitation plans were sighted in the files and were signed appropriately. Copies of EPOA were on all files and activated as required.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | 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 and located around the facility. 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 (link 1.2.7.5).  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | 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 and there are six monthly resident family focus groups in the mental health unit. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the care 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. 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. There has been one complaint that involved the DHB.There is written information on the service philosophy and practices particular to the different units. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | 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. Discussions relating to the Code are held during the quarterly resident/family meetings. All nine residents (four rest home level, four hospital level and one mental health level) and eleven relatives (two rest home level, two hospital level, three psychogeriatric level, two mental health level and two dementia level) interviewed report that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service 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. Residents all have 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. 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.ARHSS D4.1b Two psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | 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 seven Maori residents living at the facility. 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.  |
| Standard 1.1.5: Recognition Of Pacific Values And BeliefsPacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered within the service. They value and encourage active participation and input of the family in the day-to-day care of the resident. During this audit there were no residents who identified as Pacific living at the facility. 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 the relationships between the Pacific consumer their family and their community in the delivery of care for Pacific residents.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service 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. All care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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.Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two caregivers from the psychogeriatric and mental health unit could describe how they build a supportive relationship with each resident. Interviews with three families from the psychogeriatric and mental health unit confirmed the staff assist to relieve anxiety.   |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | 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 on a Tuesday and Thursday and an afterhours GP service is in place. 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. The service receives support from the District Health Board which includes visits from the mental health team and nurse specialist’s visits. Physiotherapy and dietitian services are accessed from the District Health Board. 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.The GP interviewed is satisfied with the level of care that is being provided. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whanau is recorded on the family/whanau communication record, which is held in 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. Fifteen 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. An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The 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.There is 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. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Broadview Rest Home and Hospital is a Bupa residential care facility. The service currently provides care for up to 85 residents at hospital, rest home, dementia, mental health hospital and psychogeriatric levels of care. On the day of the audit there were 24 hospital level residents including one on an ACC short term contract and one on a younger persons with disabilities contract, nine residents in the 10 bed mental health unit, 14 residents in the dementia unit, 10 residents in the psychogeriatric unit and 15 rest home residents. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. The care home manager is a registered nurse with a current practising certificate who has been in this role for two and a half years and had previously held the position of Clinical Manager for six years. She is supported by a clinical manager/RN who has worked at Broadview for seven years and been in the role for two and a half years. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | The care home manager is a registered nurse and is supported by a clinical manager/registered nurse (RN) who is employed full time and steps in when the care home manager is absent. He has had experience as clinical manager for two and a half years.The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | 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.There are procedures to guide staff in managing clinical and non-clinical emergencies. 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. Quality and risk data, including trends in data and benchmarked results are discussed in quality meetings but not in registered nurses meetings and there have not been regular staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Individual reports are completed for each incident/accident with immediate action noted and any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Incidents are benchmarked and analysed for trends (link 1.2.3.6).The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. One resident death (a resident under the mental health act) has been referred to the coroner and an appropriate section 31 notification has been made for another incident. The DHB have been notified around staffing issues on three occasions in 2015. Public Health has been notified of the recent outbreak. |
| Standard 1.2.5: Consumer Participation Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.  | FA | The services Bupa policy consumer participation - mental health units - describes the ways in which residents can participate in the service. The eligibility criteria for this service requires that all residents have (have a CTO in place). Due to the impaired functioning level of the residents, their input is limited into planning and evaluation of the service. The six monthly focus group meeting, is held in the lounge of the kauri Mental health unit, and the residents, are involved in discussions, suggestions and compliments. Supporting Families (advocate group for families are present also). However the service does have a memorandum of understanding with Balance peer support service. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Residents and family/whanau members who have enduring power of attorney, on behalf of the client have input into the service through satisfaction surveys, regular forums and informal feedback. |
| Standard 1.2.6: Family/Whānau Participation Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.  | FA | The services family/whanau and carer participation policy describes how the service receives feedback and input from family such as surveys and evaluations. Family/whanau/carer input occurs at both formal and informal levels. With residents consent or enduring power of attorney families/whanau/carer and/or significant others are asked to participate in the personal care planning process. There is a six monthly focus meeting with families and residents in the mental health unit with management in attendance for residents and families to participate in service planning and evaluation. There is also verbal feedback to staff, satisfaction surveys, and the availability of the complaints process. Four staff from the mental health unit were very aware of the importance of family/whanau involvement in resident’s treatment and actively support this. Two family members from the mental health unit report feeling included and valued and that feedback and ideas are listened to and acted on. Family/whanau are not currently used in an advisory capacity however, clear terms of reference have been developed. |
| 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 | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten 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.A register of practising certificates is maintained.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. Additional training is also offered in relation to new client needs e.g. Schizoaffective disorder - understanding, Epilespy and challenging behaviour (14) all from the mental health wing. A number of ‘safe moving and handling sessions” to capture. Six teaching sessions are provided in one month.There are 16 healthcare assistants working in the in the psychogeriatric and mental health units (the roster includes staff working in each unit as rostered). Eleven of these have completed the required dementia standards. Four (who have worked in the units longer than 12 months) are enrolled and two have been at the service less than six months. All 11 healthcare assistants who work in the dementia unit have completed the required dementia standards. The activities programme is overseen by a diversional therapist and staff on the activities team have undergone dementia related training. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The care home manager and clinical manager are registered nurses who are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. There is at least one registered nurse on duty in the hospital wings at all times and another registered nurse 24 hours per day in the mental health and psychogeriatric units (these two units have a view into each lounge from the shared office and there are cameras to provide visual monitoring of both units corridors and small lounges in the office). Additionally there is a registered nurse who covers the rest home four days per week (cover for the dementia unit is provided by the rest home RN and the hospital RN’s with support from the clinical manager). The DHB has been notified on the three occasions (of one shift each) in 2015 when RN cover was not provided in the mental health/psychogeriatric units. There has been at least one nurse in the building at all times (the hospital RN). RNs are supported by sufficient numbers of healthcare assistants. Interviews with the residents and relatives confirmed staffing overall was satisfactory.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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.Residents’ files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse including designation. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are pre-entry and admission procedures in place. Residents are screened and approved by the psychogeriatric team for entry to the psychogeriatric, mental health and dementia care units as evidenced in the two dementia care, two mental health and two psychogeriatric resident files. Residents are admitted to the mental health unit under a compulsory treatment order (CTO). The service has a dedicated assessment bed in the psychogeriatric and mental health units. Needs assessors are involved in the pre-entry screening for hospital and rest home residents. The service has a comprehensive information booklet for residents/families/whanau at entry. Eleven relatives interviewed stated they received sufficient information on the services provided.Eight admission agreements reviewed aligns with a) -k) of the ARC contract. Residents admitted to the mental health unit were under a compulsory treatment order (CTO). Exclusions from the service are included in the admission agreement.The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Written information on the service philosophy and practices particular to the dementia and psychogeriatric units including minimisation restraint, behaviour management and complaint policy are included in the information pack. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | In relation to mental health services provided: Residents in the MH unit are all assessed as requiring a secure mental health unit providing 24 hour care. There is also a 'resident on leave form'. Some residents are able to go out on leave with family and records are maintained of this. Advised that for a resident being able to do this, behaviours must be manageable and family are aware of the risks. The registered nurse described assessment and observation monitoring of residents within the unit in the first two weeks of admission. These assist to determine the interventions/triggers for management of behaviour. This form is also instigated at other times when behaviours accelerate.For all residents: The service has transfer and discharge procedures in place. Inter-facility transfers and transfers to hospital are planned and coordinated in consultation with the family/whanau as appropriate. 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 and this is documented. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | 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 not used. Two self-medicating residents had been assessed by the GP and RN as competent to self-administer. 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 using anti-psychotic medications when medications are commenced, discontinued or changed. The psychogeriatrician reviews the management plans at least monthly or earlier if required. Twenty medication charts sampled (four hospital, four rest home, four dementia, four psychogeriatric and four mental health) identified that the GP or psychiatrist had reviewed the medication chart three monthly. Temperatures of medication fridges have not been documented as per policy.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Broadview are prepared and cooked on site. There is a six weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered 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. Staff were observed assisting residents with their meals and drinks in the psychogeriatric unit and hospital. 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 satisfied with the food and confirmed alternative food choices were offered for dislikes. 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. There is evidence that there is additional nutritious snacks available over 24 hours in all units. All food services staff have completed training in food safety and hygiene and chemical safety.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the specialised care required or there are no beds available. Management communicate directly with the referring agencies and family/whanau as appropriate if entry was declined. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an initial assessment on admission including risk assessment tools. Resident needs and supports are identified through the on-going assessment process in consultation with significant others. InterRAI assessments have commenced. The diversional therapist (DT) completes an activity assessment that identifies individual activities and preferences. Cultural assessments are completed on admission for all residents. Cultural assessment were completed in all 10 resident files sampled. The care plans document the resident’s cultural needs, values and spirituality and supports (including support persons) available to ensure the resident’s needs are met.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident care plans reviewed were resident focused. All identified support needs were included in the care plans for seven of ten residents files sampled. Care plans sampled evidenced resident (as appropriate) /family/whanau involvement in the care plan process. Relatives interviewed confirmed they are involved in the care planning process. Resident files demonstrate service integration. One out of two psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Behaviour charts and behaviour monitoring charts were in use as appropriate for escalation in behaviours. Short-term care plans are used for short term needs. Short term care plans sighted in resident files were wounds, prevention of pressure injury and chest infection (link 1.3.6.1). The mental health resident files reviewed had a documented plan that identifies early warning signs and relapse prevention strategies (link 1.3.3.3). Both files documented that families are involved in care planning and care and support. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications were documented in the resident file sampled in the family/whanau contact form. The mental health and psychogeriatric units have a designated MHSOP liaison nurse and some mental health clients have their own designated MHSOP keyworker. A psychiatrist also visits the mental health unit and psychogeriatric service monthly for scheduled reviews and more often if required. Mental health resident files reviewed document that the care and support provided is consistent with needs and fully communicated to family. The need for a secure unit has been documented by referral agencies. The mental health residents whose files were reviewed receive appropriate care. There is specialist input into resident’s well-being in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the care team and diversional therapist.  Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds, skin tears and pressure areas (two sacral, two of the foot and one toes). There is evidence of GP involvement and photos for chronic wounds/pressure areas. Chronic wounds have been linked to the long term care plans. There was evidence of wound nurse specialist, dietitian and district nursing involvement in the management of wounds. Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status (link 1.3.5.2). Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Six registered nurses were able to describe access for wound and continence specialist input as required.   |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service has a qualified registered diversional therapist (DT) who oversees another qualified DT and two activity coordinators. The activity team provide individual and group activities in the rest home, hospital and dementia care units. The monthly programme is an inclusive programme where residents from all units (as appropriate) are invited into the unit where the activity is appropriate or entertainment is being held. Some activities such as baking, specific entertainment and canine friends occur in all units. There are regular outings/drives, inter-home visits for all residents (as appropriate) and involvement in community events. One on one activities occur for residents who are unable or choose not to be involved in activities. Care staff were observed at various times through the day diverting residents from behaviours in the dementia, mental health and psychogeriatric units. The individual activities observed were appropriate for older people with mental health conditions. Residents attend activities in other units as appropriate. There are resources available for care staff to use for one on one time with the resident. Staff could describe a low stimulus environment. Relatives stated they were satisfied with the activities provided and that staff were involved in activities with their loved ones, even if only passive participation. An activity profile and Map of Life is completed on admission in consultation with the resident/family (as appropriate). Activity plans sighted in all 10 files were reviewed six monthly at the same time as the care plans. Activity participation sheets were maintained in files sampled. Families are invited to the resident meetings. The service also receive feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans sampled were evaluated by the RN within three weeks of admission. Long term care plans have been reviewed at least six monthly in nine of ten files sampled (link 1.3.3.3) or earlier for any health changes. The multidisciplinary team (MDT) including the GP are involved in the care plan reviews. The GP reviews the residents at least three monthly or earlier if required. The psychogeriatrician reviews the psychotropic medications for the mental health, psychogeriatric and dementia unit residents. On-going nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Referral to other health and disability services is evident in the 10 resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to, mental health services for the older person, physiotherapist, occupational therapist, hospital specialists, field officers, speech language therapist, wound nurse, podiatrist and dietitian. The service liaises closely with the needs assessment team, geriatrician, psychogeriatric and mental health team. There was evidence of where a resident’s conditions had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low | 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 intended to be stored in locked areas. Not all chemicals are stored correctly. 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.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires on 22 June 2015. There is a maintenance/gardener staff member who works 30 hours per week and 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. 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 and secure outdoor areas in the secure units. There is outdoor seating and shade. Staff stated they have all the equipment required to provide the level of care documented in the care plans.The psychogeriatric unit and mental health unit have open plan lounges and dining areas and external areas with seating where quieter activities or family visits can take place. There are quiet, low stimulus areas that provide privacy when required.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are both shared ensuites and communal use bathrooms/toilets in the hospital. There are communal toilets and showers in the rest home, dementia, psychogeriatric unit and mental health units. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | There are only single 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. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | 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. Seating and space is arranged to allow both individual and group activities to occur. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | 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.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures are in place. An approved the fire evacuation plan is available. Fire evacuation drills take place every six months. The orientation programme and annual education and training programme include mandatory fire and security training. Staff interviewed confirmed their understanding of emergency procedures.A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency.A call bell system is in use. 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.External lighting and security systems are adequate for safety and security.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | Bupa has an established infection control (IC) programme that is implemented at Broadview. 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. The clinical manager is the designated infection control nurse with support from the registered nurses and other Bupa infection control coordinators. The IC team meets as part of the quality team meeting 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.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Broadview. The infection control (IC) nurse has not maintained his practice by attending infection control updates (link 3.4.1). The infection control team (the quality 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.  |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | PA Low | The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control coordinator who has not completed the Bug Control training as per Bupa policy. 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. 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 2015.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The 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 quality meetings (link 1.2.3.6). 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 that advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. A recent outbreak was well managed. |
| Standard 2.1.1: Restraint minimisationServices 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 staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The service has one resident with bedrails on the enabler register and 12 residents on the restraint register. All enabler use is voluntary. |
| Standard 2.2.1: Restraint approval and processesServices 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.  | FA | The restraint coordinator is a registered nurse. 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. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require 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. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | 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 reviews identified clear instructions for use of bedrails or the lap belt, approval process, risks and monitoring requirements.Restraint intervention is fully described in the care plan with daily monitoring records completed by staff. The restraint register is in place and is updated monthly. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | 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. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator is a registered nurse. The restraint committee at Broadview includes the entire quality team with restraint being discussed at each meeting. 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The service has monthly quality meetings and the minutes of these meetings are provided to staff. Monthly RN meetings have a set agenda. The Mental Health and Specialised Hospital staff have had three documented de brief meetings since the beginning of January and 1 Activities staff meeting in May 2015. They have also responded to the specific complex needs of a MH resident, and given staff additional training via a meeting and formalised a Focus group, inclusive of allied health, EPOA and staff | There has only been one staff meeting (May) in 2015 and discussion around accidents and incident and infection trend analysis were not recorded in the registered nurses meeting minutes reviewed. | Ensure that there are regular staff meetings so infection and incident trends can be discussed and that these trends are discussed in registered nurses meetings.90 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is on-going training available to staff and opportunities are provided for staff to attend a wide variety of education including compulsory topics. The care home manager and clinical manager were aware of low attendance at training sessions and advised that they have implemented a number of initiatives to attempt to address this including seeking staff feedback, running training sessions at different times and providing refreshments. This has improved attendance in recent months. | Four staff who have worked in the psychogeriatric/mental health units longer than 12 months have not completed the required NZQA dementia units. A further three staff who have been employed in the units longer than six months have not yet enrolled in the required standards. | Ensure staff who work in the psychogeriatric unit are enrolled in the required NZQA unit standards within six months of employment and complete these within 12 months of employment.180 days |
| Criterion 1.3.12.1A 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 Low | Each unit has a medication fridge for the storage of medications that require refrigeration. Three of five medication fridges have been monitored daily as per policy. Temperature have been within acceptable ranges in these fridges.  | Two medication fridges have not been monitored daily as per Bupa policy. One medication fridge has temperatures outside of the acceptable range. There is no evidence of corrective actions taken.  | Ensure all medication fridges are monitored as per policy. Ensure corrective actions are documented for temperatures recorded which are outside of the acceptable range. 90 days |
| Criterion 1.3.3.3Each 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 Low | All files sampled have all time frames met around initial care planning and assessments, long term care planning and GP reviews. Evaluations were completed six monthly for two of two mental health files sampled, two of two hospital files sampled, two of two rest home files sampled, two of two psychogeriatric files sampled and one of two dementia files sampled. Policy does not dictate how frequently early warning sign and relapse prevention plans should be reviewed, One of two mental health files sampled was for a new resident and had a current early warning sign and risk management plan. | (i) One of ten files sampled (from the dementia unit) had not had a six monthly care plan evaluation completed. (ii) One of two mental health files had not had the early warning signs and relapse prevention plan reviewed since it was developed in June 2014. The long term care plan had not been developed within three weeks for a permanent resident in the psychogeriatric unit.  | (i) Ensure all resident plans are reviewed in appropriate timeframes. (ii) Ensure long term care plans are completed within three weeks.90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The long term care plans are developed within three weeks of admission in consultation with the resident (as appropriate), family/whanau. Care plans sampled were comprehensive and described the required supports to meet the resident’s assessed needs/goals in six of 10 resident files (one mental health, one hospital, one rest home, two dementia and one psychogeriatric).  | The following care plans had shortfalls identified;(i) management of seizures for one mental health resident, (ii) current skin integrity status for one rest home resident and (iii) hospital resident with altered behaviours as per the GP and psychiatrist reviews; (vi) There was no specific behavioural management strategies/behaviour management plan in place for one psychogeriatric resident with known altered behaviours.; (v) There were no documented interventions for two residents files sampled (one hospital and one rest home) with weight loss. | (i)- (iii) Ensure care plans reflect the resident’s current assessed needs and required supports. (iv) Ensure specific behavioural management strategies/behaviour management plans are in place for psychogeriatric residents. (v) Ensure there are documented interventions to manage unintentional weight loss. 90 days |
| Criterion 1.4.1.1Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | In the dementia, psychogeriatric and mental health areas all chemicals were stored safely. Chemical bottles were all correctly labelled by the manufacturer. In the hospital kitchen chemicals were stored in an unlocked cupboard under the sink and two open bulk containers of chemicals were placed on the floor by the fridge. Chemical spray bottles were found in the resident bath rooms.  | In the hospital kitchen chemicals were stored in an unlocked cupboard under the sink and two open bulk containers of chemicals were placed on the floor by the fridge. Chemical spray bottles were found in the resident bathrooms.  | Ensure all chemicals are stored safely. 60 days |
| Criterion 3.4.1Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. | PA Low | The infection coordinator is the clinical manager and has links with the registered nurses, other Bupa infection control coordinators and Public Health if further clarification or information is required.  | The infection control coordinator has not completed the external ‘Bug Control’ training (as per Bupa policy).  | Ensure the infection control coordinator completes training to ensure knowledge of current practice. 90 days |

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

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

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

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

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End of the report.