

Bupa Care Services NZ Limited - Te Whanau Rest Home & Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Te Whanau Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 September 2015 End date: 17 September 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:	59

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Bupa Te Whanau provides rest home and hospital level care for up to 65 residents. On the day of audit, there were 59 residents. An experienced facility manager manages the service. A clinical manager and a team of registered nurses and caregivers support her. 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, general practitioner, management and staff.

The service has addressed the one shortfall from the previous certification audit around a medication register.

This surveillance audit identified improvements are required around aspects of staff training, standing orders, self-medication and documentation of interventions.

The service continues to maintain a continued improvement process around quality goals, quality system and infection surveillance.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and family are well informed of changes in resident's health. Communication with residents and families is appropriately managed. The facility manager and clinical manager have an open door policy. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

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.
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Bupa Te Whanau has an established quality and risk management programme that supports the provision of clinical care and support. Key components of the quality management programme link to a number of meetings including quality meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Quality meetings and other facility meetings are held. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Corrective actions are identified following internal audits. Health and safety policies, systems and processes are implemented to manage risk. There is an active health and safety committee. A comprehensive orientation programme provides new staff with relevant information for safe work practice. There are human resources policies including recruitment, selection, orientation and staff training and development. Staffing levels meet contractual requirements.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. The initial assessments, InterRAI assessments, care plans, reviews and evaluations are completed within the required timeframes. Residents and families interviewed confirm they participate in the care planning process. The general practitioner reviews residents at least three monthly. There is evidence of allied health professional input into the care of residents as required.

The activity programme is varied and appropriate to the level of abilities of the residents at rest home and hospital level of care. Community links are maintained. Entertainment and outings are provided. Spiritual and cultural needs are met.

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

Food is prepared on site with individual food preferences and dietary requirements assessed by the registered nurses. A dietitian reviews the menu. Dietary requirements are met. Alternative choices are offered for dislikes. Staff have attended food safety and hygiene training.

Safe and appropriate environment

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

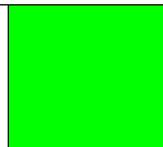


Standards applicable to this service fully attained.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Enablers are voluntary and the least restrictive option. There were four residents using enablers on the day of audit.

Infection prevention and control

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



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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. The service engages in benchmarking with other Bupa facilities.

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	3	10	0	3	0	0	0
Criteria	3	32	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is implemented at Te Whanau. The facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The complaints procedure is provided to resident/relatives at entry and is also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Discussion with residents and relatives confirmed they were provided with information on complaints and complaints forms. Two complaints made in 2015 (year to date) were reviewed and were well documented including investigation, follow-up letter and resolution.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Five residents (two rest home and three hospital) and three relatives (two rest home and one hospital) interviewed, stated they were informed of changes in the resident's health status. Incident reports reviewed for August 2015 identified relatives/family were notified of resident's incidents. Residents and family members stated they were welcomed on entry and given time and explanation about services and procedures. Resident/relative meetings take place bi-monthly. The facility manager and clinical manager 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 on access to interpreter services for residents (and their family/whānau) as required.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	CI	<p>Te Whanau is a Bupa facility. The service provides rest home and hospital level care for up to 65 residents. On the day of audit there were 25 rest home level residents (including two respite residents, two persons under ACC and one younger person) and 34 hospital level residents. The service has 18 rest home beds (includes 10 dual-purpose rooms) and 47 hospital level beds (includes a double room).</p> <p>There is an overall Bupa business plan and quality and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Te Whanau developed objectives for 2015.</p> <p>Te Whanau facility manager (RN) has been in the role since March 2013 and was previously the clinical manager for 3 years. The facility manager is supported by a clinical manager (RN) since 2013, who was the unit coordinator previously. The wider Bupa management team including a regional operations manager supports the management team. The facility manager has maintained at least eight hours annually of professional development activities 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 monthly.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	CI	<p>Te Whanau has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current and staff are informed of updates and changes.</p> <p>Te Whanau is part of the Bupa benchmarking programme with feedback provided monthly around a set of clinical indicators. 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. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Discussions with three caregivers confirm their involvement in the quality programme. Resident/relative meetings are held bi-monthly.</p> <p>Key components of the quality assurance and risk management programme link to the monthly quality improvement (including infection control), quarterly health and safety and bi-monthly staff meetings. Weekly reports by the facility manager to the Bupa operations manager and quality indicator reports to the Bupa quality coordinator, provides a coordinated process between service level and organisation. 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. There is an active health and safety committee. The service has comprehensive policies/procedures to support service delivery. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Te Whanau documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff, so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow-up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and health & safety meeting reflect a discussion of results.</p> <p>Incident forms reviewed for August 2015 identified that all 10 incident forms demonstrated clinical follow up by a registered nurse and monitoring (such as neurological observation) having been undertaken when indicated.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Records of current practising certificates were sighted. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (two caregivers, one cook, one registered nurse 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. All staff files reviewed had evidence of orientations completed. Annual appraisals are expected to be conducted for all staff. The facility manager, clinical manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local district health board (DHB).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>Te Whanau has a fortnightly 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. There is a facility manager (RN) and a clinical manager (RN) who work full time from Monday to Friday. There was sufficient staff observed to assist residents in the dining rooms with meals including activities staff. Caregivers, residents and relatives/family interviewed advised that sufficient staff are rostered on for each shift.</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All registered nurses and caregivers responsible for the administration of medications complete an annual medication competency. All medications are checked on delivery against the medication charts. Standing orders meet the requirements however have not been signed by the contracted GP. A shortfall has been identified around three monthly reviews for self-medicating residents. The previous finding around the controlled drug register has been addressed.</p> <p>The 10 medication charts sampled had photo identification and allergy status on the medication charts. The GP had reviewed the medication charts at least three monthly. Medication charts met legislative requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Te Whanau rest home and hospital are prepared and cooked on-site. There is a six weekly seasonal menu, which has been reviewed by the company dietitian. The main kitchen is adjacent to the hospital dining room and meals are served directly from the bain-marie to residents. Meals are delivered in bain-maries to the two other dining rooms within the facility.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Pureed, soft, vegetarian and diabetic desserts are provided. Cultural and religious food preferences are met as identified.</p> <p>Fridge, freezer and chiller temperatures are recorded daily. All foods are date labelled. End-cooked food temperatures are recorded for each meal. Chemicals are stored safely. Staff were observed to be wearing correct personal protective clothing. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services. Residents and family members interviewed were complimentary of the food and confirmed alternative food choices were offered for dislikes</p> <p>All food services staff has completed food safety and hygiene and chemical safety training.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p>	<p>PA Low</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff stated they are informed of any resident changes at handover. Interventions documented in care plans for the sample of files reviewed did not evidence that all care requirements have been recorded.</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Dressing supplies are available and dressing trolleys were well stocked for use. Wound initial assessment plans and wound evaluations were completed for minor wounds, and skin tears, four ulcers, one stage three sacral pressure area and two buttock pressure areas. All wounds have been evaluated within the required timeframes. Short-term care plans were in place for skin tears and minor wounds. Longstanding wounds and pressure areas were linked to long-term care plans. There are pressure area resources available. There is access to wound care specialists as required.</p> <p>Continence products are available and specialist continence advice is available as needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a diversional therapist (DT) who has been with the service three years and works full-time. She has recently qualified as a DT. The programme is Monday to Friday and meets the recreational and social needs of both consumer groups. Activities are varied and interesting and include (but not limited to); exercises, newspaper reading, cooking, walks, entertainment, outings, inter-home visits, bible study and monthly communion. Contact and individual time is spent with residents who choose not to participate in group activities. Adequate resources are available.</p> <p>Community links are maintained with schools, church groups and clubs.</p> <p>Activity assessments were completed on admission in the permanent resident files sampled. Activity plans and care plans are reviewed at the same time. Resident meetings allow for feedback on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans are evaluated within three weeks of admission. There is documented evidence of a three monthly multi-disciplinary team review including the resident (where appropriate) and family, RN, GP and activity coordinator. The registered nurses evaluated all care plans sampled. There were written evaluations evident in the residents' files. The resident's GP examines the residents and reviews the medications at least three monthly.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>A current building warrant of fitness certificate is displayed in a visible location (expiry 24 August 2016).</p>

facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. The clinical manager is the restraint coordinator. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had four hospital level residents using enablers (bedrails and lap belts) and three hospital level residents using bedrails (two) and lap belt (one) as restraints.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	In-service training has been provided in 2015 around all required subjects including; Code of Rights, abuse and neglect, dementia care, moving and handling, communication, and fire safety. The service has access to a variety of educational tools including tool box talks, in-service education sessions and self-directed learning, however, these have not been fully utilised to address low attendance at training sessions.	Attendance at staff training is low, for example; communication (12 of 55 staff), abuse and neglect (12 of 55 staff), Code of Rights (18 of 55 staff), dementia (8 of the clinical staff) and continence (12 of the clinical staff).	<p>Ensure all staff receive training relevant to their position and in the required areas.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and</p>	PA Low	The standing orders met the prescribing requirements for the administration of standing orders with the medication, dose, frequency, maximum dose and contraindications prescribed. The standing orders had been reviewed in February 2015 however, the GP was no longer providing medical services for the residents.	The standing orders had not been signed by the contracted GP.	<p>Ensure standing orders are authorised by the GP providing medical services.</p> <p>60 days</p>

medicine reconciliation in order to comply with legislation, protocols, and guidelines.				
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	There are three self-medicating residents in the rest home. All three residents have had self-medication competencies signed by the RN and GP. One of three self-medicating residents has had a three monthly competency review.	Two out of three self-medicating residents have not had three monthly self-medication competencies completed.	<p>Ensure self-medication competencies are reviewed three monthly as per policy.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	The residents/relatives stated the resident's needs were being met. Significant events are recorded in resident progress notes. Short-term care plans are available for use for short-term needs. Pain monitoring tools were in place for residents on 'as required' pain relief. Two rest home resident care plans record all care requirements.	<p>i) There were no documented interventions for two hospital residents with unintentional weight loss;</p> <p>ii) There was no diabetic management plan in place for a hospital resident who is insulin dependent.</p>	<p>i) Ensure that care plan interventions reflect the resident's current care requirements in relation to weight loss and management; ii) Ensure the management of diabetes is included in the care plans of diabetic residents.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Te Whanau is part of the central Bupa region, which includes 10 facilities. The managers in the region meet four monthly, to review and discuss the organisational goals and their progress towards these. A forum is held every six months (with national conference including all the Bupa managers). The care home manager provides a weekly report to the Bupa operations manager.</p> <p>A quarterly report is prepared by the care home manager and sent to the Bupa Quality and Risk Team on the progress and</p>	<p>The service continues to maintain continued improvement processes around quality goals and evaluations. The organisational and quality goals are reviewed regularly at the site and at organisational level.</p> <p>Quarterly quality reports on progress towards meeting the quality goals identified, are completed at Te Whanau and forwarded to the Bupa and risk team. Meeting minutes reviewed included discussing ongoing progress to meeting their goals. Te Whanau annual goals also link to the organisations goals and this is reviewed in quality meetings and in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'.</p> <p>Te Whanau 2014 goals were partially achieved. One goal around reducing bruises and skin tears by 20% from 2013 was met. Strategies were implemented and evaluated quarterly. The final quarter identified they met their target and reduced skin tears and bruises by 21%. The second goal around reducing falls by 20% was not achieved; therefore, they carried this goal over to 2015 with further strategies and ongoing evaluation of progress. Quarterly progress reports reviewed identified that they have significantly reduced falls by 67% YTD. The service implemented the following strategies to achieve the goal which included (but not limited to): (i) bi-</p>

		<p>actions that have been taken to achieve Te Whanau's quality goals.</p> <p>Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia, (eg, mortality and pressure incidence rates and staff accident and injury rates). Benchmarking of some key indicators with another NZ provider is also in place.</p> <p>Te Whanau is proactive in implementing and evaluating their quality goals. Strategies are also in place around implementation of the organisational goals, (i) B Fit programme to support health and wellbeing of our people, and (ii) manual handling.</p>	<p>monthly falls focus meeting also involves laundry and cleaners as they move around the facility and can help prevent falls. (ii) Identify the group of residents that are 'frequent fallers'. (iii) Falls champions identified. (iv) Completing the falls analysis tool to determine causes. (v) Delivering toolbox talks on falls prevention. (vi) Ongoing review of medications and use of vitamin D. (vii) Falls prevention check rounds. Develop schedule with key staff to do a quick round of facility checking senior mats, call bells, clutter, hazards etc. Feedback on progress is also shared with residents and relatives.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results</p>	<p>CI</p>	<p>There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.</p>	<p>Te Whanau continues to be active in analysing data collected monthly around accidents and incidents, infection control, restraint, and putting in place corrective actions to minimise further incidents.</p> <p>Example: (i) In June 2015, statistics showed that they were above the organisational benchmark for medication errors in the hospital. Quality indicator – corrective action plan established that included an individual analysis and corrective action on each of three medication errors. Extra training provided</p>

<p>communicated to service providers and, where appropriate, consumers.</p>		<p>Audit summaries and action plans are completed as required, depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited.</p> <p>Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Te Whanau and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.</p> <p>There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Te Whanau is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities</p>	<p>around the 5Rs and competencies re-completed for those staff involved. Medication errors dropped in July. In July, falls were above the KPI in the hospital. A quality indicator – corrective action plan was established. An evaluation of each fall was completed including corrective actions that may prevent further falls. A falls analysis tool was completed and identified the majority of the falls happened in the pm shift. Increase in check rounds implemented at high fall times resulted in a decrease in falls in August. Tool box talks were held at handovers around falls prevention strategies.</p> <p>Feedback on clinical indicators is shared with staff and residents on noticeboards and through meetings.</p>
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		for improvement are identified.	
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Benchmarking occurs against other Bupa facilities for all categories of infections. Graphs are produced and displayed for staff.</p>	<p>The service has had five consecutive months (March to July) with infection rates below the organisations key performance indicators. There have been no outbreaks. The service has maintained the continual improvement rating for surveillance.</p>

End of the report.