# Bupa Care Services NZ Limited - Eventhorpe 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:** Eventhorpe 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: 26 August 2015 End date: 27 August 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:** 78

# 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

Eventhorpe Care Home and Hospital is part of the Bupa group. The service is certified to provide rest home and hospital level care for up to 90 residents. On the day of the audit, there were 78 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 residents’ and staff files, observations and interviews with residents, relatives, staff and management.

A manager who is appropriately qualified and experienced, manages Eventhorpe. There are quality systems and processes being implemented. An induction and in-service training programme is provided. Residents and families interviewed were very complimentary of care and support provided.

The service is commended for achieving continued improvement ratings around best practice and quality goals.

Improvements are required around medication management, and reporting of allergies.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | All standards applicable to this service fully attained with some standards exceeded. |

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. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | All standards applicable to this service fully attained with some standards exceeded. |

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

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, seven days a week.

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

## Continuum of service delivery

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

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/whānau input. Care plans viewed demonstrated service integration and were reviewed at least six monthly. Resident files included medical notes by the contracted GP, and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

A diversional therapist oversees the activity team who deliver and coordinate the activity programme on site 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.

All meals ae prepared on site.

## 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. 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

|  |  |  |
| --- | --- | --- |
| 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. |

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

Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents.

The hospital has two residents with bedrails on the restraint register. One resident has an enabler (bedrail) in the hospital. Appropriate assessments, care planning, monitoring and evaluations are in place around restraint and enabler use. Restraint is reviewed at a facility and organisational level.

## Infection prevention and control

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

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 ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 2 | 45 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 2 | 96 | 0 | 2 | 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 Delivery  Consumers 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 both English and Māori. 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 ten caregivers, four registered nurses and two enrolled nurses reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. In nine of nine resident files sampled and sighted, general consents were obtained on admission. Advance directives if known were on the resident files. Resuscitation plans were sighted in the files and were signed appropriately. Copies of Enduring Power of Attorney (EPOA) were on all files reviewed and activated or in the process of being activated. Staff interviewed (ten caregivers, four registered nurses and two enrolled nurses) were knowledgeable in the informed consent process. |
| Standard 1.1.11: Advocacy And Support  Service 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 provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to 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. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | 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 residents walking to the local dairy, visiting the library and attending community celebrations. Resident/family meetings are held quarterly. |
| 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 on entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints’ register and logged onto the Bupa complaints data base. 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 suggestion box are in a visible location at the entrance to the facility. Two complaints received in 2015 were reviewed with evidence of appropriate follow-up actions taken. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | All new residents receive a resident information pack. The pack includes details around the resident code of rights; the information is also available at reception. The clinical manager/registered nurse (RN) discusses aspects of the Code with residents and their family on admission. Eight residents (six rest home level and two hospital level) and nine relatives (three rest home level and six hospital level) interviewed, report that the residents’ rights are being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service ensures that the residents’ rights to privacy and dignity are recognised and respected at all times. The residents’ room observed had personal belongings to decorate the room. Discussions of a private nature are held in either the residents’ rooms or in the family/whānau room. The caregivers interviewed report that they knock on bedroom doors prior to entering rooms and ensure doors are closed when cares are being given; this was also observed on the day of audit. Staff 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. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Currently five residents identify as Māori living at the facility. One Māori resident was interviewed and confirmed that her values and beliefs were being upheld by the service. Two resident care plans were reviewed of Māori residents (one hospital and one rest home). Both reflected the cultural needs and preferences of the residents.  Māori consultation is available through the district health board and Māori staff who are employed by the service. A kaumātua visits the service twice a year and on request. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Two staff members also identify as Māori and all caregivers interviewed are aware of the importance of whānau in the delivery of care for Māori residents. A family/whānau room is available. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. The facility’s residents are from a variety of cultures. The service identifies the residents’ personal needs and desires 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. |
| Standard 1.1.7: Discrimination  Consumers 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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | 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 twice a week. The general practitioner (GP) reviews residents identified as stable 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 services are provided on site, twelve hours per week. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.  The GP interviewed is satisfied with the level of care that is being provided. |
| Standard 1.1.9: Communication  Service 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/whānau is recorded on the family/whānau 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. A selection of 11 falls related incident forms for July identified family were 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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | Eventhorpe is a Bupa residential care facility. The service currently provides care for up to 90 residents at hospital and rest home level care. On the day of the audit, there were 44 hospital level residents and 34 rest home residents. The service reported that the 44 hospital level care residents included three respite residents and two palliative care and the 34 rest home level care residents included two respite residents. There were no residents under the short term/transitional care contract.  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.  There are annual quality goals that reviewed quarterly. The service is commended for their ongoing evaluation of quality goals.  The facility manager is a non-practising registered nurse who has many years of experience in the health sector, including managing an aged care facility. A clinical manager/RN and an operations manager support her.  The facility manager and operations 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 | A clinical manager/registered nurse (RN) who is employed full time, steps in when the manager is absent. She has been in the role for three years and has previous experience in the aged care sector. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | 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.  The service holds a series of meetings and these include a monthly staff meeting, monthly quality meeting, bi-monthly resident meetings, and monthly RN, health and safety and infection control meetings. The meeting minutes reviewed document that the service has implemented the Bupa quality process; 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.  Eventhorpe has service specific goals that include falls, skin tears, respiratory tract infection and urine infection reduction. The monthly restraint and fall focus group meeting and quality meetings demonstrates that the service continues to work towards these quality focuses.  Annual surveys include resident’s survey, which documents improved resident satisfaction year on year since 2012. This is communicated to residents and staff.  The Bupa staff survey documents that Bupa actively involves staff in quality improvements.  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.  An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule with action plans as required. Quality and risk data, including trends in data and bench marked results are discussed in staff meetings.  Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The organisation holds tertiary accreditation by ACC for their workplace safety management programme. |
| 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.  In July there were 29 incidents recorded for hospital level, including three facility-acquired pressure areas, nine skin tears and 13 falls. Review of incidents around reported pressure areas evidenced appropriate wound care plans in place and follow up. Corrective actions established to address pressure areas. All incident forms document that family have been informed where appropriate. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse.  The management team is aware of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven 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.  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. There are a wide range of competences completed by staff to ensure a high level of care related competence. Careerforce is undertaken by the caregivers.  Education and training for clinical staff is included as part of the Bupa RN specific training programme and RNs can also attend external education provided by the district health board. |
| 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 relieving facility 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 including two registered nurses and one enrolled nurse as unit coordinators. 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. Needs assessors are involved in the pre-entry screening for hospital and rest home residents. Residents are screened and the facility manager approves all admissions.  The service has a comprehensive information booklet for residents/families/whānau at entry. Eight relatives interviewed stated they received sufficient information on the services provided.  Nine admission agreements reviewed align with a)-k) of the ARC contract. 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. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has policies for transfer or exit of the service, which describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. The DHB yellow medical records envelope system is used for all transfers to Waikato Hospital. When a resident wishes to leave the facility, the NASC service is notified as reported by the registered nurse. All relevant information is documented and communicated to the receiving health provider or service and notes are photocopied. A referral form and any other relevant documentation accompany residents to receiving facilities. The family members interviewed were satisfied that they were kept well informed about referrals and/or transfer to hospital where this had occurred. Staff could describe the referral and/or transfer processes and demonstrated an understanding of residents’ right to be informed. |
| 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. The medications are stored in locked trolleys in locked rooms in the rest home and hospital.  Eighteen medication charts were reviewed (ten hospital and eight rest home). Not all medications were charted correctly and medication fridge temperatures were not being consistently documented.  All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. All RNs have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role about medicine administration. There are currently four residents who are self-administering medications and comply with the organisational policies around self-medication. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | All meals at Bupa Eventhorpe are prepared and cooked on site. There is a four weekly seasonal menu, which has been reviewed by a dietitian. Meals are delivered to each dining area. Special dietary needs and food allergies are required to be communicated to the kitchen. This was not always evident. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks in the dining rooms. 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. 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 chemical supplier checks the dishwasher regularly.  All food services staff have or are currently completing their training in food safety and hygiene. All food services staff have completed 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 were unable to provide the specialised care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau 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 ongoing assessment process in consultation with significant others. InterRAI assessments have commenced for all new residents. The activities assistant completes an activity assessment that identifies individual activities and preferences.  Cultural assessments are completed on admission for all residents. Cultural assessments were completed in all nine resident files sampled. The care plans reviewed documented 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. | FA | Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans sampled were resident centred and support needs were documented in detail. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. One resident had a specific ‘End of Life’ care plan in place. Short-term care plans were in use in three hospital files and one rest home file for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals. One respite resident file reviewed included an initial assessment, short-term care plan and regular progress notes. |
| 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 residents condition changes, 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 were documented in the resident files sampled.  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 (ten skin tears, one chronic ulcer, one skin cancer, one graze, one radiation burn, two surgical wounds, and one laceration). Chronic wounds have been linked to the long-term care plans. There was evidence of GP, nurse specialist and dietitian in the management of wounds.  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.  Short-term care plans are used for short-term needs. Short-term care plans sighted in resident files were for wounds, prevention of pressure injury and chest infections. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A diversional therapist oversees the programme. The activities programme is delivered by activity assistants, who provide a programme that covers six days per week. On the morning of audit, residents were observed being involved in activities. The programme is developed monthly and displayed in large print. A Map of Life and individualised activity plan is developed within 3 weeks of admission, and is reviewed as part of the care plan review.  There is a range of activities offered that reflect the resident needs at Bupa Eventhorpe Rest Home and Hospital and participation is voluntary. The programme is comprehensive and includes (but not limited to) van outings, walking groups, gardening, pet visits, church services and art and crafts. There are resources available for staff to use for one on one time with the residents and for group activities.  Activity participation sheets were maintained in files sampled. The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. Relatives and residents stated they were satisfied with the activities provided. |
| 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 the files sampled 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. Ongoing 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 nine resident files sampled. The service facilitates access to other medical and non-medical services. Examples of referrals sighted were to mental health services for the older person, physiotherapist, occupational therapist, hospital specialists, speech language therapist, wound nurse, podiatrist and dietitian. The service liaises closely with the needs assessment team, geriatrician 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. | FA | 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 had correct manufacturer labels. All chemicals are stored and personal protective clothing is available and seen to be worn by staff when carrying out their duties on the day of audit. Blood and chemical spills kits 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. | PA Low | The building has a current building warrant of fitness that expires on 2 December 2015. The maintenance staff member works 40 hours per week and is available on call for urgent facility matters. Planned and reactive maintenance systems are in place. It was identified that all preventative maintenance was either scheduled or had been completed. 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.  Staff stated they have all the equipment required to provide the level of care documented in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Toilet and shower facilities are of an appropriate design to meet the needs of the residents (link 1.4.2.4). There are both shared ensuites and communal use bathrooms/toilets. 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 | The facility is spacious throughout and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley, in a bed or wheelchair. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include an open plan lounge and dining areas in each unit. 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 Services  Consumers 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 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 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’ rooms have adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Bupa has an established infection control (IC) programme implemented at Eventhorpe. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service. A registered nurse has been the designated infection control nurse, with support from the clinical manager and other Bupa infection control coordinators. The IC team meets to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There 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 Eventhorpe. The relieving infection control (IC) nurse has maintained her practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes 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. | FA | The facility is committed to the ongoing education of staff and residents. The infection control coordinator with support from the clinical manager facilitates education. 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 was 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: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The 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 coordinator. Infection control data is collated monthly and reported at the facility meetings. The infection control programme is linked with the quality management programme.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents.  The hospital has two residents with restraints (bedrails). One resident has an enabler (bedrail) in the hospital. The rest home is restraint free. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments for restraint. Family are consulted as part of the authorisation and whether previous advance directives related to restraint are in place. Restraint documentation identifies involvement of family. Individual approved restraint is reviewed at least three monthly at Eventhorpe and as part of six monthly MDT review with whānau involvement. The restraint and falls focus group meets monthly and restraint is discussed as part of this group. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Bupa policies and procedures provide guidance and process to ensure a robust assessment process prior to the use of restraint. Two hospital level residents with bedrails restraint, have an assessment in place that evidences family involvement and consideration of alternatives to restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Two resident files were reviewed for use of restraint. The resident files evidence that consideration to alternatives has been considered in association with the family and GP. There are care plan interventions in place that ensure the risks associated with restraint are mitigated and monitoring is documented as occurring according to the care plan. The monthly restraint and falls focus group monitors and discusses the use of restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint and falls focus group reviews and evaluates all episodes of restraint and enablers monthly. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at regional restraint approval groups.  Individual episodes of restraint are reviewed at least monthly as part of the monthly review of restraint. Three monthly GP reviews and six monthly MDT also review individual use of restraint. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Individual approved restraint is reviewed monthly through the restraint and falls focus group meeting and as part of six MDT reviews with family involvement. Restraint usage throughout the organisation is monitored regularly and is benchmarked. Review of this use across the group is discussed at regional restraint approval groups. The organisation and facility are proactive in minimising restraint. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | There are policies and procedures in place for safe medicine management that meet legislative requirements. The medications are stored in locked trolleys in locked rooms in the rest home and hospital. Medication reconciliation is completed on delivery of medications and the RN checking the medications signs the signing sheet. Any pharmacy errors are recorded and fed back to the supplying pharmacy. Not all medication prescribed included the route for administration. The medication fridge temperatures were not being consistently recorded. | 1. Fourteen of eighteen medication charts reviewed (ten hospital and four rest home) did not have the route of administration charted.  2. The medication fridge in the ward three dispensary did not have the fridge temperatures consistently recorded. | Ensure medication is managed according to organisational policy.  60 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Moderate | The registered nurse completes a nutritional profile on admission and updates this with the six monthly care plan review or earlier if the nutritional requirements change. One rest home resident file reviewed documented food allergies that were not communicated to the kitchen. | One of nine residents’ files reviewed (rest home) did not have documented food allergies (peanuts, chocolate and honey), communicated to the kitchen. | Ensure that all food allergies are communicated to the kitchen.  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The service has an implemented preventative maintenance plan. Not all required maintenance had been completed on the day of audit, however is noted to be scheduled.  There have been numerous improvements within the home since their last audit which include (but not limited to): (i) Refurbishment of many of the rest home & hospital rooms; (ii) All rest home beds replaced; (iii) Refurbishment of the hospital lounge and dining area; (iv) Carpet replacement of all hospital wards; (v) Two new hospital ensuite rooms created; and (vi) Environmentally friendly lighting refitted throughout the facility. | The following shortfalls were identified around maintenance:  The following doors identified are scheduled to be replaced 19 October 2015. Wing Two: i) One of three communal shower doors had a hole in it; ii) Three communal toilet doors had holes in them; and iii) The treatment room door had a hole in it; (iv) The rest home shower door is bubbling.  2. The following areas in Moana Wing are having lino replaced 9th November 2015: (i) The visitor toilet had lino missing behind the toilet pan; (ii) All communal resident toilets had lino joints that were lifting; and (iii) The communal shower had rotten shower linings. | Ensure all identified maintenance is completed as scheduled.  180 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The Bupa organisation benchmarks across each of its main service groups of rest home, hospital, dementia, psychogeriatric and mental health services. Benchmarking data supports initiative development, such as the focus at Eventhorpe to reduce falls.  The Bupa policy group meets regularly and ensures all policies reflect best practice. Eventhorpe maintains a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folder. A number of core clinical practices also have education packages for staff, which is based on their policies. Bupa has robust quality and risk management systems and these are implemented at Eventhorpe. A number of committees meet on a regular basis. | The service recognised that communication was an area for improvement and implemented a series of initiatives to improve. This included regular bi-monthly family meetings and newsletters for family and staff to inform of upcoming events and sharing of ideas.  Improved admission process of proactively initiating meeting with the transferring service (most commonly the public hospital), prior to admission, as well as the resident to be admitted. This is to gain a better understanding of the resident’s need and to commence the relationship with Eventhorpe.  Previously fixed timeframes for resident review meeting have been moved to a more flexible timeframe to better meet the changing needs of the resident.  In addition, activities have been improved with additional staff and activities provided at the weekend. The physical environment of the service has also been significantly improved, with both internal and external upgrades and refurbishment.  The outcome of these improvements has improved resident satisfaction from 79% in 2012, to 96% in 2014. Complaints have reduced from 12 in 2012 to seven in 2014; Compliments have risen from 47 in 2012 to 388 in 2014.  Staff satisfaction has improved from 68% 2012 to 92% 2014. This improvement has been linked to improved staff meetings, re-orientation of all staff and the implementation of the Bupa ‘personal best’ process at Eventhorpe. |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Eventhorpe is part of the midland Bupa region and the managers from this region meet quarterly to review and discuss the organisational goals and their progress towards these. The care home manager provides a weekly report to the Bupa operations manager. The operations manager teleconferences the midlands managers regularly and completes a report to the director of care homes and rehabilitation.  A quarterly report on the progress and actions that have been taken to achieve the Eventhorpe quality goals is prepared by the care home manager and sent to the Bupa quality and risk team. 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.  Eventhorpe 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.  The service achieved the Bupa’s Care Home of the Year Oct 2014 and Midland Region Care Home of the Year November 2014.  The Resident Satisfaction Surveys has improved significantly since their last audit. | The organisational and quality goals are reviewed regularly at the site and at organisational level.  Quarterly quality reports on progress towards meeting the quality goals identified, are completed at Eventhorpe and forwarded to the Bupa and risk team. Meeting minutes reviewed included discussing ongoing progress to meeting their goals. Eventhorpe annual goals also link to the organisation’s 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'. Eventhorpe has implemented the ‘personal best’ initiative whereby staff are encouraged to enhance the lives of residents. Thirty-six caregivers/RNs have attained bronze certificate and 22 caregivers/RNs have attained a silver certificate, 15 caregivers/RNs have attained a gold certificate. Thank you notes reviewed from residents identified improvements made to their daily life because of the ‘personal best’ initiative.  Two of the three 2014 quality goals were achieved at Eventhorpe. Review of documentation and discussion with staff, identified ongoing evaluation of strategies and goals. Eventhorpe 2014 goals were partially achieved; therefore, they carried them over to 2015 with further strategies. The goal to reduce falls by 15% was achieved each quarter until the end of the year and therefore carried into 2015. The following strategies were implemented; (i) The falls focus team reviewed results of 2013 and looked for improvements, (ii) regular meetings were held to discuss issues; (iii) analysis of KPI pie chart continues to be reviewed by falls focus team monthly. Evaluations of the strategies included amendments into 2015. The August 2015 evaluation identified that the service is on track to meet their goal this year.  The 2014 goal to reduce medication errors by 15% included strategies and evaluations around the effectiveness of the strategies quarterly, throughout the year. The goal was achieved and medication errors have reduced significantly.  The 2014 goal to reduce pressure areas by 15% included strategies and evaluations around the effectiveness of the strategies quarterly, throughout the year. The goal was achieved and pressure areas have reduced significantly with ongoing toolbox talks and awareness of staff.  The other goal around reducing the number of acquired skin tears in the hospital wing by 10% is still an ongoing issue, however documentation reviewed identified the service continues to evaluate this and ensures the effectiveness of strategies is re-evaluated and new actions/strategies are implemented. Regular ‘tool box’ talks are held with staff. |

End of the report.