# Bupa Care Services NZ Limited - Winara Rest Home

## 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:** Winara Rest Home

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

**Dates of audit:** Start date: 18 November 2015 End date: 19 November 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:** 66

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Bupa Winara Care Home provides rest home, hospital and dementia level care for up to 81 residents. During the audit, there were 66 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 the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

The care home manager is a registered nurse with more than eight years’ experience in aged care management. An experienced clinical manager/registered nurse supports her. Quality systems and processes have been embedded. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care. Feedback from residents and families was positive about the care and services provided.

This certification audit has not identified any areas for improvement. The service has been awarded continuous improvement ratings around the implementation of the quality & risk management system, good practice and infection surveillance.

## Consumer rights

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| 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. |

Bupa Winara endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints are actively managed and well documented.

## Organisational management

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

The Bupa Group governs the facility. Bupa has a business plan in place and the facility operates a quality plan, which includes goals for the calendar year. Goals are documented for the service with evidence of annual reviews. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. The quality and risk management system is overseen and coordinated by Bupa head office staff. A risk management programme is in place, which includes managing adverse events and health and safety processes.

An annual resident/relative satisfaction survey is completed. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvement. 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.

## Continuum of service delivery

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

There is a comprehensive admission package available prior to or on entry to the service. The sample of residents’ records reviewed provides evidence that the provider utilises the InterRAI assessment to assess, plan and evaluate care needs of the residents. A registered nurse develops resident outcomes and goals in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Changes to health status and interventions required are updated on the care plans to reflect the residents current health status. Resident files include notes by the general practitioner and other allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies annually. The medicine records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

An activities programme is implemented separately for the rest home/hospital area and for the dementia care unit. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the groups of residents.

All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans. Nutritious snacks are available 24/7 in the dementia care unit.

## Safe and appropriate environment

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

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. There is a reactive and planned maintenance system in place. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. There is a safe external walking path and gardens for the dementia care residents that are freely accessible.

All rooms are single and have hand basins. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme. A first aider is on duty at all times. The facility has ceiling heating and the temperature is comfortable and constant.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. A registered nurse is the restraint coordinator. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using enablers and five residents with a restraint. Restraint management processes are adhered to.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | 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 programme has been reviewed annually. The infection officer (registered nurse) is responsible for coordinating/providing education and training for staff. Infection control training is provided at least annually for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. Information obtained through surveillance is used to determine infection 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.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 47 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 97 | 0 | 0 | 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](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 Code of Health and Disability Services Consumers’ Rights (the Code) is prominently displayed in the facility. Code of Rights brochures are readily available for consumers of the service. The service provides families and residents with information on the Code on entry to the service. Staff receive training about the Code during their induction to the service, which continues through ongoing education and training. Interviews with five caregivers (two dementia, two rest home/hospital and one hospital), two registered nurses (RNs) and two activity coordinators 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 | The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code. There were signed general consents including outings in nine of nine resident files sampled (three rest home, four hospital, two dementia level of care). Resuscitation treatment plans and advance directives were appropriately signed in the nine files reviewed. There was evidence of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. Copies of enduring power of attorney were held as appropriate in the files reviewed.  Discussions with caregivers and two registered nurses (RN) confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.  Nine admission agreements sighted had been signed within the required timeframe. Discussion with seven family members identified that the service actively involves them in decisions that affect their relative’s lives.  Informed consent links to the quality system via satisfaction surveys and internal audits. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code and advocacy pamphlets on entry. The care home manager, clinical manager, registered nurses and caregivers interviewed were aware of advocacy and support options for residents. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff have received 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. The service also provides assistance to ensure that they are able to participate as desired and in safe manner. |
| 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. The care home manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation including follow up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner.  Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. The only three 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 | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager and clinical manager discuss aspects of the Code with residents and their family on admission.  Discussions relating to the Code are held during the quarterly resident/family meetings. All five residents (three rest home level and two hospital level) and seven relatives (one rest home level, four hospital and two dementia level) interviewed, reported that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. There is a policy on abuse and neglect and staff have received training. |
| 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 beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Staff interviewed report that they value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Care plans sampled documented cultural needs.  Māori consultation is available through local iwi links and Māori staff employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. |
| 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 identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. The facility’s residents are from a variety of cultures. 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 | The Bupa Code of Conduct for staff is included in each employee information pack given when they commence employment. Job descriptions identify responsibilities for each position. There is policy to guide staff practice, which covers gifts, gratitude and benefits and delegations of authority. Bupa management provide guidelines and mentoring for specific situations. All care staff interviewed are aware of professional boundaries. Staff were aware of the actions they should take if they believe a staff member is not maintaining a professional approach to practice. |
| 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. Two general practitioners (GPs) visit the facility twice a week. Physiotherapy services are available by referral.  There is a regular in-service education and training programme for staff.  Performance at Bupa Winara is currently benchmarked in three areas (rest home, dementia and hospital) against other NZ Bupa facilities. Graphs and data are provided to management and displayed for staff. |
| 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. Accident/incident forms identified family had been kept informed. Relatives interviewed stated that they were kept informed when their family member’s health status changes. Resident/family meetings held quarterly provide an opportunity for feedback on the service.  An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and read to residents who require assistance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Winara rest home is a Bupa residential care facility. The service currently provides care for up to 81 residents at hospital, rest home and dementia level of care. On the day of the audit, there were 36 hospital residents, 19 rest home residents (including three respite care residents) and 11 dementia care residents. There were no residents under the medical aspect of the certification. All residents other than those on respite contracts are under the ARC contract. There are 14 dual-purpose beds in the rest home unit.  There is a regular review of the quality goals at the site and organisational level. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Bupa Winara 2015 quality goals have been reviewed. Quarterly quality reports on progress towards meeting the quality goals are completed and forwarded to the Bupa Quality and Risk team.  The care home manager is a registered nurse with a current practising certificate. She has been at Winara for over 18mths previously working at the care home at another Bupa home since 2007 in the role over two years and is supported by an experienced clinical manager who has been in the role for three years. Support is also provided by the operations manager who visits at least monthly.  The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service. Care home managers and clinical managers attend annual organisational forums and regional forums six monthly. |
| 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 | During a temporary absence, the clinical manager covers the care home manager’s role. The Bupa operations manager supports the service. The clinical manager takes overall responsibility for clinical care and reports to the care home manager. Registered nurses and senior caregivers assist her. |
| 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. | CI | A quality and risk management programme is well established. Interviews with the managers and staff reflected their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. There is regular review of policies. 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. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. The service has exceeded the standard around corrective action planning and implementing the quality and risk management system to evidence improvements to resident outcomes. Interviews with staff and review of meeting minutes and quality action forms demonstrate a culture of quality improvements. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.  There is a comprehensive health and safety, and risk management programme in place. Hazard identification, assessment and management policy guides practice. Bupa Winara has a health and safety coordinator who monitors health and safety and hazards.  Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds and sensor mats. |
| 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. Eleven accident/incident forms were reviewed (from the first two weeks of November 2015). These included rest home, five falls and one other from the rest home and two falls, one bruising, one pressure injury and one other from the hospital. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse.  The provider confirmed their understanding around essential notifications. There have been no reportable events. |
| 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. Nine staff files reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a period of time and during this period they do not carry a clinical load. Newly employed caregivers complete an orientation booklet that has been aligned with foundation skills unit standards with the opportunity to complete further unit standards.  There is an annual education and training schedule in place. All staff are encouraged to attend at least 12 sessions a year, including compulsory sessions. Opportunistic education is provided via toolbox talks. The caregivers undertake aged care (Careerforce) education and training. Eight registered nurses have completed InterRAI training. All caregivers working in the dementia unit have completed the required dementia unit standards. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The care home manager and clinical manager are both registered nurses and share the on call after hours with other registered nurses. There is an RN on duty 24 hours a day in the rest home/dual-purpose beds wing and an RN on duty 24 hours a day in the hospital wing. The RN in the rest home/dual-purpose beds oversees the dementia unit. There were 19 residents in the rest home wing, 36 residents in the hospital wing (12 were rest home level and 24 hospital level) and 11 in the dementia unit. On a morning and afternoon shift, there are two caregivers in the dementia unit, two in the rest home and four in the hospital. On the night shift, there is one caregiver in each unit. Additionally one caregiver commences in the rest home wing at lunchtime and works across both the morning and afternoon shifts. Interviews with the residents and relatives confirmed staffing overall was satisfactory. The care home manager advised they are currently recruiting more casual staff to assist when staff are sick. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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. |
| 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 | Residents and relatives stated they were well informed upon admission. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the Code, how to access advocacy and the health practitioners code. A needs assessment is completed prior to entry for full-time care. The services provide respite service at all levels of care. There is written information on the service philosophy and practices particular to the dementia care unit included in the information pack. The admission agreement reviewed aligns with a) -k) of the ARC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. There is a transfer plan policy. A record is kept and a copy is kept on the resident’s file. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification of appointments and transfers. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made. |
| 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. | FA | Medications are managed appropriately in line with legislative requirements. Registered nurses administer medications in the hospital and caregivers administer medications in the rest home and dementia unit. All medication competent staff have completed annual medication competencies and attended annual medication education. RNs have completed additional competencies for syringe driver. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.  The standing orders are current and meet the requirements for standing orders. There was one self-medicating resident in the rest home on the day of audit. The RN and GP completed and reviewed a self-medication competency. There was evidence of monitoring of the self-medicating resident.  Eighteen resident medication signing-sheets were sampled. Signing sheets correspond to instructions on the medication chart. Antipsychotic medication management plans were in place for residents on these medications.  Eighteen medication charts sampled (four dementia care, eight hospital and six rest home) were pharmacy generated, up to date and reviewed at least three monthly by the GP. There was photo identification and allergy status documented on all medication charts sampled. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The main cook oversees the food services. The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in bain maries to each kitchenette and served from bain maries. A kitchen hand is based in the hospital unit kitchenette and serves the main meal and morning/afternoon teas. The cook (interviewed) receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in kitchen. Special diets such as diabetic desserts, vegetarian, purred meals and alternatives for dislikes are accommodated. Finger foods and nutritious snacks are available in the dementia unit 24 hours.  End cooked food temperatures are recorded on each meal daily. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Chemicals are stored safely. Cleaning schedules are maintained.  Food services staff have completed food safety training and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is an admission information policy. The service would record the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry were declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission the RN completes an initial assessment booklet including risk assessment tools. The outcomes of risk assessments on admission were reflected in the initial care plans sampled. All residents have an InterRAI assessment completed within three weeks of admission and six monthly or earlier due to health changes. Long-term care plans reflect the outcomes of the assessment process.  Dementia care resident files sampled included an individual assessment for specific dementia needs that included identifying diversional, motivation and recreational requirements. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Service delivery plans sampled were comprehensive, and demonstrate service integration and input from allied health professionals. Care plans describe the resident’s needs, goals and supports/interventions to achieve their desired goals. Residents and families interviewed confirm care delivery and support by staff is consistent with their expectations. Residents and families stated that they are involved in the development of the initial and long term care plan. There is documented evidence of family involvement in care plan process.  Specific needs for residents with dementia were included in the care plans and identified behaviours, interventions and de-escalation techniques.  Short-term care plans are utilised for short-term needs and changes in health status. |
| 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 alters, the registered nurse initiates a review and if required a GP or specialist consultation. There is documented evidence written on the family contact record of family notification when a residents health status changes. Relatives confirmed they are notified of any resident concerns and any significant events. Relatives state the staff approachable if they wish to discuss their relative’s health at any time. Residents and relatives confirm their needs are being met.  Monitoring forms in use (sighted) includes continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning charts, pain monitoring tool and neurological observations. Behaviour monitoring charts are commenced for any new or escalating behaviour (sighted). The mental health services are readily available as required.  Staff report there are adequate continence supplies available. Resident urinary continence assessment and bowel management has been completed for residents with identified continence problems. The clinical manager states there are nursing specialists for wound and continence management readily available for advice and education. |
| 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 | The service employs a team of activity coordinators to implement activity programmes in the rest home, hospital and dementia care unit. One of the team is a qualified diversional therapist (DT). A casual DT who assists on outings and covers for annual leave supports the team. There are caregivers in the dementia unit who take on the activity role to cover for the dementia unit activity coordinator. A company occupational therapist oversees the activity programmes. Bupa provide regular DT workshops and education.  There are separate programmes for the rest home/hospital and dementia care units. The programme is delivered Monday to Friday in the rest home and hospital units with a seven-day (11 am to 5 pm) programme in the dementia unit. The programmes include meaningful activities that meet the needs, abilities and preferences of the resident groups. A variety of activities was observed occurring in the lounges throughout the facility. Bupa has set activities on the programme delivered with the flexibility to add site-specific activities, entertainers and outings. Some activities are integrated for rest home, hospital residents and dementia care residents (under supervision). The activity coordinators spend one on one time for residents who are unable or choose not to participate in the programme. Care staff in the dementia care unit include activities with residents as part of their day. Resources are readily available.  The individual activity plan in all resident files sampled identifies activities and community links that reflect the resident’s normal patterns of life. The activity plan (incorporated into the My Day, My Way long-term care plan is reviewed at the same time as the care plan six monthly at the multidisciplinary review. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The initial care plan and long-term care plans were reviewed and evaluated by the registered nurse at least six monthly in seven of nine files sampled. Two residents (rest home and dementia care) had not been at the service long enough for a review. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident. Family members are invited to attend the MDR. Written evaluations were documented identifying the resident needs/goals as met or unmet. Changes to health were reflected in the long-term care plan of the files reviewed. Short-term care plans are evaluated at regularly. |
| 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 a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.  Discussions with the clinical manager and registered nurses identified that the service has access to GPs, ambulance/emergency services, allied health professionals, dietitians, physiotherapy, continence and wound specialists. |
| 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 | There is a chemical/substance safety policy and waste management policy. Chemicals are stored safely throughout the facility. Safety data sheets are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff at the point of use. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Staff have attended chemical safety education. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The rest home, dual-purpose beds and dementia unit are within one main building. The hospital building is connected to the main building by a covered walkway. Both buildings have a current warrant of fitness that expires 2 June 2016. Reactive maintenance and a 52 week planned maintenance schedule has been maintained. Contractors for essential services are available 24/7. Medical equipment including hoists and wheel-on scales have been calibrated. Electrical equipment has been tested and tagged. The hot water temperatures are monitored twice weekly (on rotation of rooms) and maintained below 45 degrees Celsius.  The corridors are wide with handrails to promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and garden landscaping has been well maintained. There is outdoor furniture and seating and shaded areas. There is wheelchair access to all areas.  The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.  The dementia unit has one lounge with outdoor access. The space and seating arrangements provide for individual and group activities. There is a separate dining area. Single rooms provided quiet, low stimulus areas and privacy when required. A safe and secure outside walking area and gardens area is easy to access for dementia residents. |
| 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 | All bedrooms have hand basins. There are adequate numbers of communal showers/toilets for each wing. Toilets are also located near the communal areas. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Residents interviewed report their privacy is maintained at all times. |
| 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 | All bedrooms are single. A 14-bed rest home wing has been refurbished with carpets and curtains. The dual-purpose beds are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. The bedrooms in the dementia care unit are spacious. Residents are encouraged to personalise their bedrooms as desired. |
| 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 | There is a separate lounge and dining room in the rest home. There is a large spacious open plan lounge/dining room in the hospital wing. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture well arranged to facilitate this. Seating and space is arranged to allow both individual and group activities to occur. There is a family room in the hospital wing.  There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. There is a separate lounge and dining room. |
| 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 | All laundry and personal clothing is laundered on-site. The laundry is located in a basement area with a dumb waiter for the transport of linen to and from the laundry. There is a defined clean/dirty area. There are adequate linen supplies sighted in the facility linen-store cupboards. There is a dedicated laundry and cleaner over the seven-day week. Cleaning trolleys are well equipped and stored safely when not in use. Residents and relatives interviewed are happy with the laundry and cleaning services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and six monthly fire drills. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. There are emergency kits and two thousand litres of stored water at the facility. Call bells are evident in residents’ rooms, lounge areas and toilets/bathrooms. The facility is secured at night. |
| 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 | The facility has underfloor heating throughout the communal areas and ceiling heating in the bedrooms. All communal rooms are well ventilated and light. Residents and family interviewed, stated the temperature of the facility is comfortable. There is plenty of natural light in residents’ rooms. |
| 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 | The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a job description for the infection control officer with clearly defined guidelines. The infection control committee and the governing body are responsible for the development of the infection control programme and its annual review. There are two monthly infection control committee meetings held with a reporting process to management and governance.  The facility has adequate signage and hand sanitisers appropriately placed throughout the facility. Visitors are asked not to enter if they have contracted or been in contact with infectious diseases. |
| 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 | The infection control committee includes staff from across the services. The infection control officer attends the three monthly infection control meetings at the district health board. Meetings include training. Regional Bupa infection control coordinators meet twice yearly, which includes education. The facility also has access to an infection control nurse at the district health board (DHB), public health, GPs, nurse practitioner, laboratory and expertise within the organisation. |
| 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 defining roles, responsibilities and oversight, the infection control team, training and education of staff. The manual was last reviewed September 2014 by the governing body in consultation with infection control personnel. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control officer is responsible for coordinating/providing education and training to staff. All staff receives infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand hygiene competency. Staff attend annual infection control education as per the training planner. The infection control officer provides toolbox sessions to keep staff updated/informed on infection control practice.  Resident education is expected to occur as part of providing daily cares. Service delivery plans can include ways to assist staff in ensuring this occurs. There is evidence of resident and visitor education around influenza and the prevention of the spread of infection. |
| 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. | CI | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infection control data is collated monthly and reported at the infection control committee meetings and quality and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Infection control data is on display for staff. Benchmarking occurs against other Bupa facilities. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs/NP that advises and provides feedback/information to the service. There have been no outbreaks.  The service has been awarded a continuous improvement rating around the reduction of urinary tract infections and respiratory infections. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures (reviewed October 2015) include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no enablers in use on the day of audit.  Staff interviews evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. |
| 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 | A registered nurse in the hospital is the restraint coordinator. A job description defines the responsibility of the role. The restraint coordinator and restraint committee approve the use of restraint and restraint processes. The restraint coordinator attends six monthly teleconferences with the quality risk team at head office. Staff receive annual education on the use of restraint and complete annual restraint competencies. There were five hospital level residents on the day of audit with restraint usage (two with lap belt and bedrails and three with lap belt only). |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The registered nurses, in partnership with the resident and their family/whānau, undertake assessments. There is a restraint assessment tool available. Two resident files for residents with restraint included completed assessments. Ongoing consultation with the resident and family/whānau was also identified. Assessments consider the requirements as listed in Criterion 2.2.2.1 (a – h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails and lap belts). The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint as the last resort. Monitoring records for seven residents demonstrated that restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring requirements are documented at the required frequency for each episode of restraint use. A current restraint register is maintained, which provides an auditable record of restraint use. Trial of removal of restraint (as appropriate) is monitored closely. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation considers the areas identified in 2.2.4.1 (a) – (k). Restraint files sampled demonstrated that restraint use is reviewed three monthly during the quality meetings, as part of the three-monthly medical review and at the time of the six-monthly care plan evaluation. Families are included as part of this review where possible. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use is discussed at the regional restraint approval group meetings. Reduction of restraint is an ongoing target at the facility as they constantly work on the reduction of restraint within the facility every year. The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes challenging behaviours. The company has a dementia care specialist who is readily available to the service. |

# Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |

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

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

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

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

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| **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 | 1) The service identified resident weights were being recorded monthly however early interventions and trends for weight loss was not being identified. Managing weight loss had become reactive with a number of residents becoming at risk due to lack of follow-up/management of weight loss.  2) A clinical file audit (post surveillance) September 2014 identified a lack of reporting and recording of incidents/events and interventions. A change in the health status of a resident was not always being followed up in a timely manner. | 1) A corrective action plan for preventative weight loss management was developed April 2015 in consultation with management and staff. Resident monthly weights were entered into an electronic database that calculated weight loss and recorded a history of a resident’s weight from admission. The weight graphs were easy to read and easily identified any trends in weight loss or gain which is important to monitor for some medical conditions.  All residents have a mini nutritional assessment completed on admission. Protein drinks are made up daily and distributed to the kitchenette fridges (as sighted in the fridges). Staff provide protein drinks to all residents at risk, including those residents with small appetites and those who have been unwell/hospitalised. The provider confirmed their understanding around essential notifications. The cook (interviewed) is notified of any residents requiring protein drinks and makes up the required quantity daily. Fortified foods such as Sustagen puddings are supplied to the kitchenettes. There are plentiful nutritious snacks available 24 hours. Resident files reviewed evidenced residents at risk having protein drinks had gained weight and stabilised. Family feedback during the multidisciplinary reviews, comment on how well their relative looks. The weight management audit was 92% in February 2015 and 100% in August 2015.  2) The service introduced weekly clinical file reviews. Registered nurses have allocated residents for whom they have the responsibility of care plans, MDTs and clinical file reviews. The RNs read through the previous week’s progress notes and any GP visit notes. The review identifies any areas that require follow-up such as weights, wounds, infections and next of kin communication. All documentation and charts are checked to ensure information is current, reviewed and evaluated. Care plans and short-term care plans are reviewed, updated and evaluated. There is evidence in the resident progress notes of a weekly written clinical review, which captures the resident’s progress over the previous week identifying any areas requiring further clinical or medical input. The GP (interviewed) states the RNs know their residents well and there is prompt reporting of any resident concerns, which has reduced the number of hospital admissions. A clinical file audit in October 2015 was 100%. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Bupa Winara is proactive in developing and implementing quality initiatives. Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Bupa Winara and document actions that have improved outcomes or efficiencies in the facility. Responsibilities for corrective actions are identified. Reports provided to the quality meeting include areas identified for improvement and actions initiated.  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.  Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (e.g., quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited.  Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Winara 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.  There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Winara is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified | Winara is active in analysing data collected monthly around accidents and incidents, infection control, restraint etc. When areas have been above the benchmark Quality indicator- corrective action plans (QI-CAP) have been implemented that include an evaluation process. In March 2015 falls were noted to be above the benchmark in the dementia unit. Initiatives were introduced including (but not limited to) increasing snacks, monitoring of at risk residents and review for infections when falls increase. Evaluation shows that falls decreased the next months. A QI-CAP was developed September as a result of three choking episodes in the dementia unit. Initiatives were implemented including providing staff with further training on how to manage a choking event. Evaluation identified decreased choking with changes to care planning, supervision and staff knowledge. Another example where falls were above the benchmark in the hospital in relation to falls Sept/Oct 2015. Individual actions were implemented for each at risk resident, strategies were shared with staff and further training was provided to staff around falls prevention. Falls were noted to decrease in the November benchmark. |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | CI | The service plans and operational structures combine to provide a comprehensive quality development and risk management system. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12-month period.  Quality action forms are utilised at Winara to document actions that have improved or enhanced a current process or system or actions, which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, for example, the quality meeting and through newsletters.  The facility manager provides a documented weekly report to the Bupa operations manager. The operations manager visits as required and completes a report to the general manager, care homes. Bupa head office also completes an annual onsite audit to ensure quality systems are established, implemented and evaluated to evidence improvements to service delivery. | In 2014, statistics showed that they were above the organisational benchmark for incidents of skin tears and bruising. One of their goals for 2014 was to reduce the high infections of skin tears and bruising to residents by 20% or more. The service implemented strategies including the review of residents moving and handling plans, staff training and up to date competencies for moving and handling for all staff, staff training in the importance of hydration of the residents to promote supple skin. Results for 2014 (compared against 2013) evidenced a reduction in skin tears and bruising in the rest home, in the dementia unit and in the hospital, with an overall result of 33% reduction in skin tears and bruising within the facility.  Bupa‘s fall strategy for the next three years is to reduce the number of falls across the organisation by 10%. Winara developed a quality action plan to work towards this at a service level. Actions implemented included (but not limited to); developing an action falls committee, develop a visual chart for staff to see where the falls were happening, encourage staff from across all three areas to be involved in the falls committee, review the ergonomics of the chairs and furniture in the high-falls areas, monitor footwear and use medical reviews to review causative agents. Evaluation is ongoing monthly and falls have reduced in the rest home, and dementia unit overall. Strategies are continually evaluated to determine effectiveness. |
| Criterion 3.5.7  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. | CI | August 2014 surveillance results for urinary tract (6.5%) and respiratory infections (10.9%) for residents in the dementia unit were above the organisations benchmarking levels.  Respiratory tract infections and urinary tract infections (UTI) for hospital residents in 2014 were consistently above the benchmarking levels. The service has comprehensively addressed these issues. | The service identified an opportunity for improvement to reduce the incidence of respiratory and urinary tract infections for hospital level and dementia level residents. Both groups of residents were dependant on care staff for personal and hygiene cares. Benchmarking findings were shared with the nursing and care staff and suggested actions to address the issue were discussed. As part of their corrective actions, an Infection Control Focus group was initiated and meets every two months and then this information is brought to the two monthly IFC meeting. The group reviewed the data, to assist in identifying any trends and looks at additional activities that would focus on these trends to reduce the incidents to be below the benchmarking targets.  All staff were involved in the review of infection control practices and resident hygiene cares. Staff education focused on hand hygiene, good resident toileting and perineal hygiene. In addition to formal education, there were toolbox talks and updates at handovers to keep staff informed on infection rates, trends and outcomes resulting from improved practice. The incontinence representative visited the facility six monthly providing refreshers on continence management.  Resident and family education included a visit from the nurse practitioner regarding influenza vaccines. Staff were encouraged to have an influenza vaccine. In 2015, 65% of staff received an influenza vaccine and 91% of residents were vaccinated. There has been a reduction in respiratory infections to date for hospital residents.  Staff identified difficulty in maintaining good hydration levels for residents. Fluids in other forms such as jellies and flavoured drinks were introduced. Recommended skin cleaners and creams were used following toileting, which successfully healed moist skin folds.  There has been a significant reduction in UTIs to date for the hospital and dementia care residents. The reduction in UTI for residents in the dementia unit has also led to reduced delirium related behaviours. |

End of the report.