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

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Stokeswood Rest Home & Hospital

**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: 7 September 2016 End date: 8 September 2016

**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:** 86

# 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** |
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|  | 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

Stokeswood Care Home and Hospital is part of the Bupa group. The service is certified to provide rest home, hospital and dementia level care for up to 87 residents. On the day of the audit, there were 86 residents.

This unannounced surveillance audit was conducted against a subset of the 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.

The care home manager is appropriately qualified and experienced. Feedback from residents and relatives is positive.
One of the two shortfalls identified at the previous audit have been addressed. This was around referring residents for reassessment. Further improvements are required around care interventions and this finding has been identified as high risk.

This audit identified that improvements are required around staff training, incident reporting of pressure injuries, evaluations and enabler documentation.

## 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. |  | Standards applicable to this service fully attained. |

Residents and family are well informed, including any changes in resident’s health. The care home manager and clinical manager have an open door policy. Complaints processes are implemented and complaints and concerns are managed and documented and learning’s from complaints shared with all staff.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Stokeswood has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Stokeswood is benchmarked against other Bupa facilities. Incidents documented demonstrated immediate follow-up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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

Resident records reviewed provide evidence that the registered nurses utilise the InterRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration. Resident files include three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

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

There are activities programmes in place for the rest home, dementia unit and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and provided. The organisational dietitian reviews the Bupa menu plans.

## Safe and appropriate environment

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

The building holds a current warrant of fitness and the buildings and grounds meet the needs of the resident groups.

## 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. |

A Bupa restraint policy includes comprehensive restraint procedures including restraint minimisation. A documented definition of restraint and enablers aligns with the definition in the standards. There were three restraints and four enablers being used.

## Infection prevention and control

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

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

## 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** | 0 | 12 | 0 | 2 | 2 | 1 | 0 |
| **Criteria** | 0 | 35 | 0 | 2 | 2 | 1 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet.There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow-up letters and resolution reviewed demonstrated that complaints are well managed. Discussion with six residents (four rest home and two hospital) and relatives, confirmed they were provided with information on complaints and complaints forms. Complaints reviewed were well documented including investigation, follow-up letter and resolution. One complaint involving the Health and Disability Commission in April 2016 has been closed with no further action required by the facility.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if family/whānau have been informed (or not) of an accident/incident. Incident forms reviewed identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around family being informed. Families often give instructions to staff regarding what they would like to be contacted about and when an accident/incident of a certain type occurs. This is documented in the resident files.Four relatives (two dementia, one rest home and one hospital) interviewed stated that they are always informed when their family members health status changes. There is an interpreter policy and contact details of interpreters.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa Stokeswood provides rest home, hospital and dementia level care for up to 87 residents. The 43 beds in the rest home wing were full and included one resident on respite care and one on a long-term chronic conditions contract. The 24-bed hospital wing was full. Nineteen of the 20 dementia unit beds were occupied. One hospital resident was on an ACC funded contract and one dementia resident was on a long-term chronic conditions contract. Stokeswood set specific quality goals for 2016 and there is monthly review of all goals.The care home manager has been in the role since 2011. She is supported by a clinical manager who has been at the service for many years. Managers and clinical managers attend annual organisational forums and regional forums six monthly. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Stokeswood has an established quality and risk management system.The service has policies and procedures that meet accepted good practice and adhere to relevant standards. Policies are current and staff are informed of updates and changes.Key components of the quality-management system link to the monthly quality, health and safety, and infection control meetings, registered nurses meetings and staff meetings at Stokeswood. Quality system processes, which are defined in the quality plan, have not been fully implemented for the service (link 1.2.4.3 and 1.3.6.1). Weekly reports by the care home manager to the Bupa operations manager, and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident and infection benchmarking reports provided to Stokeswood for rest home, hospital and dementia level care. Internal audits are completed according to the Bupa schedule. Corrective action plans are developed when service shortfalls are identified. There is a comprehensive hazard management, health and safety, and risk management programme in place. There are facility goals around health and safety. The health and safety committee meets monthly and there is a current hazard register for Stokeswood.  Falls prevention strategies are in place. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | PA Low | Individual incident reports sampled that had been completed for incidents/accidents had immediate action noted. Not all incidents identified had an incident form completed. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Incident reports are assessed for a means to prevent recurrence before being signed off. All incident forms reviewed documented immediate follow up by a registered nurse including completion of neurological observations for all unwitnessed falls or falls with a possible head injury. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health was promptly notified of a non-norovirus outbreak in August 2016. Two unstageable pressure injuries had section 31 notifications completed during the audit.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Moderate | A register of practising certificates is maintained.Six staff files reviewed and included two registered nurses (one the clinical manager and one a unit coordinator), two caregivers, the kitchen manager and an activities coordinator. Files reviewed included appropriate employment documentation and up to date performance appraisals and documentation.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice including around caring for those with dementia. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. Completed orientation booklets are on staff files. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. An annual education schedule is being implemented. In addition, opportunistic education is provided by way of toolbox talks. Attendance at in-service education sessions is low. A competency programme is in place with different requirements according to work type. Seventeen caregivers work in the dementia unit. Eight have completed the required dementia standards and six of the other eleven have not yet been employed for 12 months.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | An organisational staffing policy aligns with contractual requirements and includes skill mixes. There is at least one registered nurse on duty 24 hours per day (this includes the hospital coordinator during the day, during the week). Additionally, there is a registered nurse as unit coordinator in the rest home, who works 40 hours per week and a unit coordinator in the dementia unit who works three days per week. Additional registered nurses are used if acuity increases, particularly in the dementia unit.Also, the clinical manger is a registered nurse and works 40 hours per week.Interviews with relatives and residents all confirmed that staffing numbers were adequate. Caregivers interviewed stated that there were sufficient numbers of staff rostered on each shift. |
| 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 | Medication rooms/cupboards were checked across the three areas. Registered nurses in the hospital and senior caregivers in the rest home and dementia unit, administer medications. All staff administering medications have completed an annual medication competency. Registered nurses also complete an annual syringe driver competency. The service uses a robotic roll system for medications. All medications are checked on delivery against the medication chart and discrepancies are fed back to the supplying pharmacy. There is a small supply of hospital stock kept in a locked cupboard in the hospital medication room. The 12 electronic medication charts sampled were clear and easy to understand, they included photo ID and allergies. The medication instruction contained information on crushable medications and warfarin precautions. Antipsychotic medication management plans were in place for residents on these medications. All medication charts sampled showed evidence of being reviewed by the GP 3-monthly. All prescribed medications had been electronically signed as administered including the effectives of as required medications. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Moderate | Stokeswood continues to prepare and cook all meals on site in the main kitchen. The food is transported to the dining rooms in bain-maries. The temperature of the food is checked before leaving the kitchen and again before being served. There is a cook on duty daily who is supported by a morning and evening kitchenhand. All kitchen staff have an up to date food safety and hygiene certificate. There is a kitchen manual and a cleaning schedule. Not all areas of the kitchen were clean. Chemicals are stored in a locked cupboard and safety datasheets are available. Personal protective equipment is worn as appropriate. There are Bupa seasonal menus on a six weekly cycle and these have been approved by a consultant dietitian. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are written on the kitchen whiteboard. Normal and moulied meals are provided. Snacks are available for residents in the dementia unit. Fridge and freezer temperatures are recorded daily (sighted). Temperatures are recorded on all chilled and frozen food deliveries. All food in the chiller, fridges and freezers are dated. Stock is rotated by date. The kitchen is well equipped. Food satisfaction surveys are done annually. Residents and relatives interviewed spoke positively about the food provided. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA High | All resident files reviewed had a documented care plan however, care plans did not all reflect current needs. The previous shortfall remains. When a resident’s condition changes, the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.Wound assessment, wound management and evaluation forms and short-term care plans were in place for all minor wounds in the hospital (five skin tears, one graze and chronic wound), the rest home (one skin cancer) and the dementia unit (two skin tears). There were five facility acquired pressure injuries and appropriate management of these residents and care was not always evident. Monitoring charts were utilised; examples sighted included (but not limited to), weight and vital signs, blood glucose, food and fluid, turning charts and behaviour monitoring as required. Turning charts were not reflective of regular turning. Two restraint-monitoring charts sampled had been consistently maintained. This is an improvement since the previous audit.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities staff at Bupa Stokeswood provide an activities programme over six days per week and care staff assist when activities staff are not present. There is a dedicated activities assistant located in the dementia unit between Tuesday and Thursday in addition to the other activities staff. Group activities are voluntary and developed by the activities staff. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. The service has two vans that are used for resident outings. The group activity plans were displayed on noticeboards around the facility. There is one programme for the rest home and hospital and residents attend which activity they wish to attend. A separate programme is provided in the dementia unit and dementia residents often join (under supervision) concerts and events with the other residents. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept to ensure all such residents are included. All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff. The resident files reviewed included a section of the care plan was for activity and has been reviewed six monthly. Residents interviewed spoke positively of the activity programme with feedback and suggestions for activities made via meetings and surveys. The organisation has an occupational therapist that oversees the activity programme, and is available for activity staff to discuss recreational programmes and provides education for activity staff twice a year. The residents are maintaining links with the community and continuing activities they participated in outside of the facility. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | In files sampled, the registered nurses documented care plan evaluations. Six monthly multi-disciplinary reviews (MDT) were completed by the registered nurse, with input from caregivers, the GP, the activities coordinator and if applicable, the physiotherapist in four of five long-term files sampled. Family are invited to attend the MDT review. Files sampled also had short-term care plans available to focus on acute and short-term issues. These were not always evaluated 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 | The previous audit identified that referrals for re-assessment for two residents have not been initiated. All resident files sampled for this audit were for residents at the correct level of care and one resident file (link hospital tracer) had been reassessed for a higher level of care. There was also evidence in files of referral to mental health services, the dietitian and the wound nurse specialist. Registered nurses interviewed could describe appropriate processes for referrals. The previous shortfall has been addressed.  |
| 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 service has a current building warrant of fitness prominently displayed. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly and reported at the quality, infection control and staff 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. A non-norovirus outbreak was contained within the dementia unit and appropriately managed in August 2016. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | A restraint policy in place states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Currently the service has three residents on restraint and four with enablers. Residents using enablers have voluntarily signed a consent form. Assessments are completed and enabler use is reviewed six monthly.  |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Policies and procedures require that all pressure injuries are documented on an incident form. This had not occurred for two current pressure injuries. Pressure injuries reported through the incident reporting system are benchmarked. Grade three and four and unstageable pressure injuries are treated as ‘category one’ incidents and notified to the Bupa head office, who in turn make section 31 Notifications to HealthCERT. | Two pressure injuries (one unstageable for a hospital resident, and one grade two for a rest home resident) did not have an incident form completed. | Ensure an incident form is completed for every pressure injury.90 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | The service provides regular in-service education and sessions have been provided that address all required areas. However, attendance numbers at trainings have been low. The management team are aware of the need for staff working in the dementia unit to have the required unit standards. A Careerforce coordinator from another Bupa facility has recently commenced coordinating this training at Stokeswood, but has not yet had time to ensure all required staff have completed the standards. | (i) Attendance at core in-service training has been low, meaning insufficient staff have adequate training. For example: Code of Rights – 12 of 70 staff, Abuse and neglect – 9 of 70 staff, Cultural safety – 5 of 70 staff, pressure injury prevention – 11 of 70 staff.(ii) There are five staff that have worked in the dementia unit for more than 12 months that have not completed the required dementia standards. | (i) Ensure that sufficient staff attend education sessions to provide certainty that staff have received training in required areas.(ii) Ensure all staff working in the dementia unit have completed the required dementia standards within 12 months.60 days |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | The kitchen has regular cleaning schedules and all were signed as completed. However, the kitchen was unclean in areas. Specific food preparation benches were clean.  | The kitchen including the inside of fridges and freezers and the doors of these, corners and shelves were dirty and had food particles around them. | Ensure the kitchen is maintained in a clean and hygienic manner.30 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA High | Appropriate wound management was documented and implemented for all minor wounds. Pressure injury assessments, management and the management of associated risks was lacking. Monitoring records were well documented except for two hourly turning charts. Respite residents have a short stay assessment completed and then reviewed and updated for each re-admission. This had not occurred for the respite file sampled. Three of five care plans sampled documented interventions for identified needs. | i) Pressure injury prevention and management was not well documented or implemented for the following: a) hospital resident (tracer) care plan had not been updated since March 2016 (the resident became hospital level care in June 2016), and does not reflect the resident’s current needs. The care plan does not reflect the needs identified in the InterRAI assessment. Pressure injury risk management is not addressed in the care plan; b) Unstageable pressure injury 1: Photographic evidence demonstrates the wound was unstageable on 16 August 2016. The unit coordinator reports she was not aware that the wound was classified as unstageable. There is no evidence the clinical manager reviewed the wound. The short-term care plan had not been reviewed since 27 July 2016 and was no longer current; c) Unstageable pressure injury 2: The wound started as a sacral rash. Progress notes and wound documentation do not document when the wound became a pressure injury. The wound has not been reassessed and was not being treated as a pressure injury. No short-term care plan had been developed. An incident report form had not been completed for this pressure injury (link 1.2.4.3). The two hourly turning chart did not evidence regular two hourly turns; d) One grade 2 PI was wrongly graded on the assessment and another had no grade documented; and e) A grade 2 PI in the rest home had no documented review since 24 August 2016.ii) One rest home level respite care resident had not had the assessment or short stay care plan updated for this admission.iii) Two enabler files sampled (hospital level) had no interventions relating to enabler use in the file. | i) Ensure that pressure injury prevention, and management documentation and implementation of care measures is appropriately completed, for all residents with pressure injuries. ii) – iii) Ensure that all resident care plans reflect each residents identified current needs.7 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Registered nurses review long-term care plans at least six monthly (with one sighted exception link 1.3.6.1) and these are updated when needs change. Short-term care plans when developed, (link 1.3.6.1) are reviewed appropriately in the rest home and hospital but not the dementia unit. | Three short-term care plans in the dementia unit had not been evaluated, and one long-term care plan (also dementia unit) had not been evaluated in the past year. | Ensure long-term care plans are evaluated at least six monthly and that short-term care plans are evaluated in appropriate timeframes.60 days |

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

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

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

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

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End of the report.