# Bupa Care Services NZ Limited - Telford Rest Home & hospital

## Introduction

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

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

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

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

The specifics of this audit included:

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

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

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

**Dates of audit:** Start date: 9 February 2017 End date: 10 February 2017

**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:** 41

# 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 Telford provides rest home and hospital level care for up to 53 residents. During the audit there were 41 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board and Ministry of Health. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The care home manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse).

This certification audit identified that improvements are required in relation to the implementation and sign off of corrective action plans, the completion and review of assessments and care plans within the required timeframes, aspects of care planning, medication management and the monitoring of hot water temperatures.

## Consumer rights

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

Bupa Telford Rest Home and Hospital 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 demonstrated an understanding of residents' rights and obligations. 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 needs are identified. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Services are planned, coordinated and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. The integrated residents’ files are appropriate to the service type.

## Continuum of service delivery

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

The care home manager takes primary responsibility for managing entry to the service with assistance from the clinical manager and registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. Care plans are based on the InterRAI outcomes and other assessments. They are clearly written and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied. There are policies in place to guide staff in the safe management of medication in line with legislation and guidelines. General practitioners review residents. Meals are prepared on site under the direction of the Bupa dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

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

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. 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. 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 approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident using restraint and one resident with an enabler. Restraint management processes are being implemented.

## Infection prevention and control

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

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 officer (registered nurse) is responsible for coordinating/providing education and training 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. The infection control officer 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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 45 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 3 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (four caregivers, three registered nurses, one activity coordinator, the clinical manager and Bupa relieving care home manager), reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the seven residents’ files reviewed (three hospital - including one resident under the residential disability services contract, and four rest home – including one resident under the residential disability services contract). Advance directives if known were on the residents’ files. Resuscitation plans for competent residents were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had been provided.Seven resident files reviewed had a signed admission agreement. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information about the national Health and Disability Advocacy service is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility in three languages. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident and relative meetings are held bi-monthly. Monthly newsletters are provided to residents and relatives.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the care home manager using a complaints’ register. The complaints register review included verbal and written complaints (seventeen in total for 2016) with evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, meeting timelines, corrective actions when required, and resolutions. A trend in complaints was noted in January - July 2016 and corrective actions were implemented which evidenced resolution of the issue.Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestion box are placed at reception.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. All four residents (two rest home – including one person under residential disability services – physical/intellectual, and two hospital 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 and residential disability care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | 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. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. One Māori resident interviewed (hospital) confirmed that Māori cultural values and beliefs are being met. Māori consultation is available through the documented iwi links. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. All residents and relatives interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. Not all care plans reviewed included the resident’s spiritual and cultural needs (link to 1.3.6.1). |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with four caregivers could describe how they build a supportive relationship with each resident. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A house GP visits the facility one day a week and an afterhour’s service is provided by Taranaki Base Hospital. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.The service receives support from the district health board, which includes visits from the mental health team and nurse specialist’s visits. Physiotherapy services are provided on site three hours per week. A dietitian is also available for consultations. There is a regular in-service education and training programme for staff. A podiatrist is on site every six weeks. The service has links with the local community and encourages residents to remain independent.Bupa Telford is benchmarked against other Bupa services. If the results are above the benchmark, a corrective action plan is developed by the service. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident’s file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Eighteen accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member’s health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa Telford Care Home provides hospital (geriatric and medical) and rest home level care for up to 53 residents. There were 28 rest home level residents and 13 hospital level residents in the hospital/rest home units. This included four residents under the residential disability contract (one hospital and three rest home). A vision, mission statement and objectives are in place. Progress towards the achievement of Annual goals (2016) for the facility has been reviewed by the relieving care home manager. The annual goals for 2017 have been developed and are awaiting the approval of the Bupa Quality and Risk team before being communicated to staff.The service is currently managed by a Bupa relieving care home manager who is a registered nurse with 16 years’ experience of managing Bupa aged care facilities. She is supported by a clinical manager/registered nurse (RN) who has been employed at the facility for six months. The care home manager and clinical manager are supported by a Bupa regional manager. The regional manager advised that an experienced care home manager has recently been appointed and will be orientated into the role in March 2017 with support from the Bupa relieving manager.The Bupa relieving care home manager and CM have maintained over eight hours annually of professional development activities related to managing an aged care service.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | During the temporary absence of the care home manager, the clinical manager covers the care home manager’s role with the support of the regional manager and the care home manager from another Bupa site located in New Plymouth. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the Bupa regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes.The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents’ falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the quality and applicable staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. There is evidence of corrective actions being communicated to all staff but not consistently evaluated and signed off by management when completed. Health and safety policies are implemented and monitored by the health and safety committee. The health and safety committee was established in November 2016. Prior to this time Health and safety was evidenced to be consistently discussed as an agenda item in monthly staff meetings. Three health and safety representatives were interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. An employee health and safety programme (Bfit) is in place, which is linked to the overarching Bupa National Health and Safety Plan. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes, use of a safety harness in a resident’s chair (restraint), bedrail as an enabler, sensor mats and use of low beds. Toileting plans and intentional rounding are examples of strategies being implemented.  |
| 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. Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system.The relieving care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided. |
| 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 | Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (two RNs, one clinical manager, two caregivers, one activities coordinator, one cook and one laundry assistant) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. The service identified a gap in staff attendance at staff meetings in 2016 as attendance ranged from 45-75%. The service had been providing a questionnaire to those who had not attended meetings to provide them with an opportunity to maintain their knowledge or learn new information. Bupa Telford now provides two full day in-service education sessions six monthly to all care staff. The first education session was presented in January 2017 with positive feedback from attendees received and achieved a high attendance rate.Registered nurses are supported to maintain their professional competency. Six registered nurses are employed and five have completed InterRAI training. There are implemented competencies for registered nurses including (but not limited to) medication, catheter care, wound management and syringe driver competencies.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a care home manager Monday - Friday and a clinical manager (RN) Monday - Friday. RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. Separate laundry and cleaning staff are employed seven days a week. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being held securely in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts held in a separate folder. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy. Information gathered on admission is retained in residents’ records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the service’s contracts. Seven admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Fourteen medication charts were reviewed (eight hospital-including one YPD, and six rest home). There are policies available for safe medicine management that meet legislative requirements. Not all medication charts sampled met legislative prescribing requirements. Not all ‘as required’ medication had indications for use charted and not all resident allergies were noted. The medication charts reviewed identified that the GP had not reviewed all resident’s medication three monthly and not all allergies were noted. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses blister pack for medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Standing orders are in use for one resident however the prescribing of this medication did not meet standing orders prescribing requirements. There were two residents self-medicating on the day of audit (one rest home and one hospital). Both residents had met the required assessment, consent, and review process.The medication fridge temperatures are recorded regularly and these are within acceptable ranges. Advised, that Telford is changing to using One Chart from 4th April with remote training for all registered staff on 6th March. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Bupa Telford are prepared and cooked on site. Bupa policies and procedures are available. The national menus have been audited and approved by an external dietitian. There is a four weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met. Meals are plated and served from the kitchen to the two dining areas which are located next to the main kitchen. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed or are currently completing their food safety course. There is specialised crockery such as lip plates and mugs and utensils to promote resident independence with meals. Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes. |
| 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 | The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. 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 | The facility has embedded the InterRAI assessment protocols within its current documentation. Bupa assessment booklets and care plan templates were completed on admission and reviewed six monthly as part of the long-term care plan evaluation (link 1.3.3.3). Additional assessments as required were completed for the management of continence, behaviour, and wounds. InterRAI initial assessments and assessment summaries were evident in printed format in all long-term resident files. The information obtained through the assessment processes is reflected in the care plans. Five of six RNs are InterRAI trained.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Care plans reviewed demonstrated service integration and input from allied health. All resident care plans sampled were resident centred. Residents and family members interviewed confirm they are involved in the development and review of care plans. Care plans were amended to reflect changes in health status. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. Not all interventions documented in the progress notes, were transferred to a short-term care plan or updated in the long-term care plan. There was evidence of service integration with documented input from a range of specialist care. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | A written record of each resident’s progress is documented. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. The care plans reviewed did not always document interventions that reflected the resident’s current needs, and the documented interventions were not always specific enough to guide the care staff (link 1.3.5.2). 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 they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. 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 14 of 14 wound care files sampled (ten hospital – six skin tears, two ulcers and two stage-two facility acquired pressure injuries, and four rest home - one surgical wound, two skin tears and one chronic wound).Monitoring charts sighted included (but not limited to), vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs an activity coordinator who works 25 hours per week Monday to Friday. Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. Activities provided at Bupa Telford meet the abilities of the rest home, and hospital residents. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. Residents were observed participating in one-on-one and groups activities during the audit.Residents are encouraged to maintain links with the community with visits to the local shops, and other community groups. There are regular entertainers to the home and residents go on regular outings and drives. There was evidence that the residents admitted under a YPD contract, had a range of interventions documented to allow them to participate in a range of cultural, education and leisure activities consistent with their needs and preferences. The family/resident completes a Map of Life on admission, which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated into the long-term care plan, and is reviewed at the same time as the care plan in all resident files reviewed. 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 | Care plans reviewed had been evaluated by registered nurses but not all in the required timeframes (link 1.3.3.3). Written evaluations describe the resident’s progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the reviews. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, physiotherapist, activities coordinator and resident/family. The family are notified of the outcome of the review if unable to attend. There is evidence of review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| 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 service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | The building has a current building warrant of fitness which expires 20 July 2017. A maintenance person was employed in January 2017 to replace the position that had been vacant since August 2016. The acting care home manager and Bupa property officer provided maintenance cover whilst the position was vacant. There is a Bupa 52 week planned maintenance schedule for the site and a process in place for reactive maintenance.The maintenance person is employed 30 hours a week. Afterhour’s maintenance cover is provided by the acting care home manager. Medical equipment including hoists and weighing scales have been calibrated. Electrical testing and tagging has been completed annually. The hot water temperatures have not been monitored from August to February and the monitoring undertaken in February identified hot water temperatures in excess of 45 degrees Celsius in resident areas. The wide corridors and rails 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 gardens are well maintained. There is outdoor furniture and seating and shaded areas. There is safe wheelchair access to all communal areas. There is an outdoor designated smoking area.The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms have access to hand basins. Not all rooms have ensuites. There are adequate numbers of communal toilets and shower rooms. There are communal toilets located close to communal areas in the rest home and hospital areas. Toilets have privacy locks. 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. The rest home rooms and hospital rooms are spacious enough to manoeuvre transferring and mobility equipment, to deliver the assessed level of care. Residents are encouraged to personalise their bedrooms as desired.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are two separate lounges and one conservatory. There are separate dining rooms for the rest home and hospital residents that adjoin the main kitchen. There is a hair dressing salon. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Seating and space is arranged to allow both individual and group activities to occur. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty seven days a week. The laundry and cleaning staff have completed chemical safety training. There is an entry and exit door with defined areas for clean and dirty laundry. The cleaners’ trolleys are stored in locked areas when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes. 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/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 fire drills occur six monthly. 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 adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Call bells are evident in residents’ rooms, lounge areas and toilets/bathrooms. The facility is secured at night and is patrolled by a security company and 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 radiator heating throughout the personal and communal areas. All communal areas and bedrooms are well ventilated and light. Air conditioning units are in the lounges and dining rooms. Residents and family interviewed, stated the temperature of the facility is comfortable.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control officer is a registered nurse and she is responsible for infection control across the facility. The committee and the Bupa governing body in conjunction with Bug Control, is responsible for the development of the infection control programme and its review. The infection control programme is well established at Bupa Telford. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, Bupa quality & risk team. There has been one outbreak since the previous audit, which was evidenced to have been well managed from the meeting minutes, infection log and debrief meeting minutes reviewed. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Bupa Telford. The infection control (IC) officer has maintained best practice by attending infection control updates through Bug Control and Bupa infection control training days. The infection control team is representative of the facility. External resources and support are available through the Bupa quality & risk team when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. |
| 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. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to) handwashing, outbreak management, and infection prevention & control and standard precautions. The infection control officer has attended education both in-house and by an external provider to enhance her skills and knowledge. The infection control officer has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.A number of toolbox talks have been provided including (but not limited to) preventing UTIs, standard precautions, use of gloves.  |
| 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and the Infection Control Practitioner at the DHB that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had one hospital resident requiring the use of two restraints (chair harness and bed rail); and one hospital resident requiring the use of an enabler (bedrail). |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator and for staff are documented and understood, confirmed in interviews. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Three files of psychogeriatric residents using restraint (t-belts) were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).  |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident’s restraint care plan and one care plan reviewed reflected the risks associated with the use of a chair harness and bed rail when in use. An internal restraint audit monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify two hourly checks was sighted on the monitoring forms for one resident requiring the use of a restraint. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly, evidenced in one resident file where restraint was in use. Restraint use and the evaluation of the continuing need for restraint of each resident using restraint, was evidenced discussed in the RN meeting minutes reviewed. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. The annual review for 2016 has not yet been disseminated to the facility from Bupa head office. The 2015 review of the restraint programme was sighted. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective action plans have been documented when service shortfalls are identified through internal audits or other quality management processes. Seventeen corrective action plans were developed in 2016; nine were signed off as implemented. | Eight of the seventeen corrective action plans developed in 2016 have not been signed off as completed. | Ensure corrective action plans are implemented and signed off when completed.90 days |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | The GP prescribes all medication to be administered to the resident on admission and is responsible for reviewing resident medications at least three monthly. Not all residents had a documented three monthly medication review. Not all medication had a route of administration documented and not all ‘as required’ medication had indications for use charted. Standing orders were charted for one resident and the charting of this medication did not meet the requirements of the MoH Standing Order Guidelines 2016.  | (i) Six of fourteen medication charts (three hospital, three rest home) did not have the route of administration documented; (ii) Five of fourteen medication charts (two hospital and three rest home) did not have ‘indications for use’ charted for all ‘as required’ medication; (iii) One hospital resident with standing orders charted did not have an explanation as to why the order was required, the circumstances in which the standing order applies, the contraindications, the indications for which the medicine is to be administered, the maximum dose in 24 hours, the number of dose(s) of the medicine for which the standing order is valid, and the period for which the standing order applies; (iv) Four of fourteen medication charts (one hospital, three rest home) did not evidence at least a 3 monthly medication review by the GP; (v) Two of fourteen medication charts (rest home) did not have known allergies noted in the clinical notes documented on the medication profile. | i-iii) Ensure that all medications prescribed meet all legislative, contractual and MoH Medication Guidelines (MoH Standing Orders 2016, and Medicines Care Guides for Residential Aged Care 2011). (iv) Ensure that all residents medication is reviewed at least three monthly by the GP. (v) Ensure that resident medication allergies are noted on the medication chart. 60 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The registered nurse is responsible for documenting an initial assessment and care plan within 24 hours of admission, and an InterRAI assessment and long-term care plan within 21 days of admission. In the files sampled, initial assessments and initial care plans had been completed in the required timeframes. Not all InterRAI assessments and long-term care plans had been completed in the required timeframes. The service has thirteen visiting GPs. There is one contracted GP who visits weekly and is available for acute visits during business hours. Afterhours, medical care is provided by Taranaki Base hospital. Not all residents had a documented assessment by a GP within 48 hours of admission. The registered nurse completes a review of the InterRAI assessment and then updates the long-term care plan when there is a significant change in health condition. Although InterRAI assessments and long-term care plan reviews were completed, these were not always completed at least six monthly. A review scheduled has now been documented and implemented. An improvement in the timeliness of the reviews has been noted since October 2016.  | i) Five of seven files reviewed (three hospital - including one resident admitted under a YPD contract and two rest home residents) had not and their initial InterRAI assessment and long-term care plan documented within the required timeframes.ii) Three of four (hospital) residents had not been seen by a GP within 48 hours of admission. iii) Three of three residents that required a review of their InterRAI and long-term care plans had not had the InterRAI re-assessments or long-term care plan reviews completed within the required timeframes.  | i) Ensure that all initial InterRAI assessments and long-term care plans are completed within the required timeframes. ii) Ensure that all new residents have been seen by a medical officer within the required timeframes. iii) Ensure that all InterRAI re-assessments and long-term care plans are reviewed within the required timeframes. 90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | The RN uses information gathered from assessments and observations to document a care plan that describes the interventions required to meet the identified care needs. Not all interventions noted in the progress notes were transferred to a care plan. The RN reviews information gathered from assessments, monitoring charts, observations, and interviews with residents, staff and families to develop the care plan. Not all interventions for assessed care needs were documented in sufficient detail to guide the care staff and not all interventions that had been implemented were documented in the care plan. | (i) Two of seven files reviewed had interventions noted in the progress notes that had been implemented but not transferred to a short-term care plan or updated in the long-term care plan; for a) one hospital resident with suicidal ideologies and b) one rest home resident (tracer) with weight loss. (ii) One resident who identifies as Māori did not have cultural needs documented. (iii) Three of seven files reviewed (hospital) did not have interventions documented in sufficient detail to guide care staff in the management of end of life care, behaviour management, and management of a chronic skin condition. | (i) Ensure that all interventions documented in the progress notes are transferred to the care plan. (ii) Ensure that all residents who identify as Māori have any cultural needs documented. (iii) Ensure all care plans include interventions. 90 days |
| Criterion 1.4.2.4The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | The service has recently employed a maintenance person for 30 hours per week. The position had been left vacant since August 2016. The maintenance person ensures daily maintenance requests are addressed and the planned maintenance schedule is implemented. Essential contractors are available 24 hours. The maintenance person carries out regular checks of transferring equipment and the company van. No hot water temperature checks were completed August 2016 to February 2017. The hot water checks completed on 7 February 2017 identified 9 resident areas where hot water temperatures were above 45 degrees Celsius. No corrective actions were taken at the time the temperatures were noted, however the plumber was asked to visit the site when the raised temperatures were brought to the attention of the acting care home manager during the audit.  | i) Hot water temperatures have not been monitored between August 2016 and February 2017. ii) The hot water temperatures monitored on the 7 February 2017 showed hot water temperatures from 45.6 to 50 degrees in nine resident areas. No corrective action had been taken to address the hot water temperatures at the time the recordings were taken.  | Ensure hot water temperatures in resident areas do not exceed 45 degrees Celsius and where corrective action is required this is implemented in a timely manner 30 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.

|  |
| --- |
| No data to display |

End of the report.