# Bupa Care Services NZ Limited - Waireka Care Home

## Introduction

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

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

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

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

The specifics of this audit included:

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

**Premises audited:** Waireka Care Home

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

**Dates of audit:** Start date: 12 April 2017 End date: 13 April 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:** 53

# 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 Waireka is part of the Bupa Group and is certified to provide rest home and hospital level of care for up to 60 residents. There are 38 rest home beds and 22 hospital beds. On the day of audit there were 53 residents.

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

The service is managed by a care home manager who is a registered nurse and has been in the position for four years. She is supported by a clinical manager/RN who has been in the role since August 2016. The management team and staff are supported by a Bupa regional operations manager who visits monthly and more often if required.

The residents and relatives spoke positively about the care provided at Bupa Waireka facility.

There was one area identified for improvement around the completion of assessments.

The service has been awarded two continuous improvement ratings around good practice and quality initiatives.

## Consumer rights

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

Bupa Waireka 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. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families. Cultural, religious and spiritual needs are respected. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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

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 embedded in practice. Corrective actions are implemented and evaluated where 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.

## Continuum of service delivery

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

There is a comprehensive admission package available prior to or on entry to the service. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Residents’ files include three-monthly reviews by the general practitioner (GP). 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 complete education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three-monthly by the GP.

An integrated activities programme is implemented that meets the needs of aged care residents. The programme includes community visitors and outings, entertainment and activities.

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

## Safe and appropriate environment

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

There is an approved evacuation scheme and emergency supplies for at least three days. A first aid trained staff member is on duty at all times.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

All bedrooms are single occupancy with adequate numbers of toilets and showers. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible.

## 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. |

There is a restraint policy in place that states the organisations philosophy to restraint minimisation. Currently the service has two residents on restraint (lap belts) and no residents on enablers. The clinical manager is the restraint coordinator for the facility.

## 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 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** | 1 | 48 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 2 | 98 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The 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 (six caregivers, two registered nurses (RN), one diversional therapist, one cook, the clinical manager and care home manager), reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the eight residents’ files reviewed. 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.  Long-term residents’ files reviewed had a signed admission agreement. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information 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. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. 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. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner (HDC). 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. One complaint received in 2016 reflected evidence of responding to the complainant in a timely manner with appropriate follow-up actions taken. The complaint reviewed was signed off by the care home manager as resolved. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. A manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Five residents (four rest home and one hospital level) and six relatives (two rest home and four hospital) interviewed reported that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. 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. The care home manager is the privacy officer. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were no residents who identify as Māori living at the facility. There are links with the local Pahiatua Marae. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. 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. All care plans reviewed included the resident’s spiritual and cultural needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. Two general practitioners (GP) visit the facility for eight hours per week and provide an after-hours service. The GP interviewed was satisfied with the level of care that is being provided. Physiotherapy services are provided on-site as required. A dietitian is also available on a referral basis. A podiatrist is on-site every three months. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent. Bupa has established benchmarking groups for rest home, hospital and dementia services. Bupa Waireka is benchmarked against the rest home and hospital services data. If the results are above the benchmark, a corrective action plan is developed by the service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fourteen 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 Ministry of Health ‘Long-term Residential Care in a Rest Home or Hospital – what you need to know’ is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa Waireka is certified to provide rest home and hospital (medical and geriatric) level of care for up to 60 residents. There are 38 rest home beds and 22 hospital beds. At the time of the audit there were 53 residents in total (31 rest home residents and 22 hospital level residents). There were three residents in GP funded beds and one resident was on a health recovery rehabilitation contract. All other residents were under the Aged Related Residential Care (ARRC).  A vision, mission statement and objectives are in place. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Bupa Waireka has set specific quality goals for 2017. Annual goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and sent to the Bupa quality and risk team on the progress and actions that have been taken to achieve the Waireka quality goals.  The service is managed by a care home manager who is a registered nurse and has been in the position for four years. She is supported by a clinical manager/RN who has been in the role since August 2016. The clinical manager has worked as a RN at Bupa Waireka for seven years. The care home manager and clinical manager are supported by a regional operations manager who visits monthly and more often if required. The care home manager has 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 Bupa relieving facility manager or clinical manager supported by the regional operations manager covers the care home manager’s role. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | 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 operations 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 injuries, 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. Corrective actions are established, implemented and are signed off when completed.  Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the Health and Safety Committee. The health and safety officer was 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. The resident satisfaction survey for 2016 improved to 95% overall satisfaction from 91% overall satisfaction in 2015.  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 sensor mats and chair alarms. |
| 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. Fourteen 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 care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one clinical manager, two RNs, three caregivers, one diversional therapist and one health and safety officer) included a recruitment process (interview process, reference checking and 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. Seventy-nine per cent of the total staff have attained at least one Bupa Personal Best certificate. A total of 83% of caregivers have attained a Careerforce qualification with the remaining 17% of staff currently enrolled on Careerforce education programmes.  Registered nurses are supported to maintain their professional competency. Six registered nurses are employed. Three of eight registered nurses (including the care home manager and clinical manager) have completed interRAI training. There are a number of implemented competencies for registered nurses including (but not limited to) medication competencies and wound care. |
| 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. Bupa Waireka has a four-weekly roster in place, which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. There is a FTE care home manager and clinical manager. The care home manager works Sunday-Thursday. There is a registered nurse on duty on each shift seven days per week. Registered nurses are supported by sufficient numbers of caregivers. Seven caregivers (three rest home and four hospital) are scheduled to work during the AM, five caregivers (two rest home and three hospital) during the PM shifts and two (one rest home and one hospital) during the night shift. 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. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. |
| 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 overarching Bupa 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. Eight 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 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. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The service uses an electronic medication management system. An RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy. The medication rooms in the two areas are clean and well organised. The medication fridges have temperatures recorded daily and these are within acceptable ranges.  Registered nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as the second checker have also completed medication competencies.  Sixteen electronic medication charts were reviewed (eight rest home and eight hospital). Photo identification and allergy status were on all 16 charts. All medication charts had been reviewed by the GP at least three-monthly. All electronic resident medication administration-signing sheets corresponded with the medication chart. Seven residents have been assessed as competent to self-administer some prescribed medications and competency is evidenced to be reviewed at three-monthly GP medical review. Each resident has a locked drawer for safe storage of medications. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The cook oversees the food services and is supported by kitchen staff on duty each day. The national menus have been audited and approved by an external dietitian. The main meal is at lunchtime. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in bain-marie to the hospital kitchenette where they are served. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated.  End cooked food temperatures are recorded on each meal daily. Serving temperatures from bain-marie are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.  Food services staff have complete on-site food safety education and chemical safety.  In the dining area, two resident’s religious preference (to be segregated from other residents at meal times) is observed and respected and a dining table has been placed away from other residents as requested.  The cook consults with residents prior to their birthday and makes and decorates their favourite cake to have at afternoon tea or share with friends or family.  Residents and family reported that they were very satisfied with the menu and presentation of meals and that “the cooks and kitchen assistants do an amazing job.” |
| 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 residents should this occur and communicates this to 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 | Bupa assessment booklets on admission and care plan templates were completed for all the resident files reviewed. The interRAI initial assessments and six-monthly reassessments were not evidenced to be completed within the required contractual timeframes in three permanent resident files reviewed (link 1.3.3.3). Additional assessments for management of behaviour, wound care and restraint were completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed demonstrated service integration and input from allied health. All resident care plans sampled were resident-centred and support needs and interventions are updated as resident status changed. Residents and family members interviewed confirm they are involved in the development and review of care plans. Short-term care plans are in use for changes in health status and are evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There is 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 | Residents and families interviewed reported their needs were being met. Family members interviewed praised the service, the care staff and the management team. 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 wounds. All wound care plans included a short-term care plan and written progress notes to assist review and evaluation of the wound.  One the day of audit, there was a total of 11 wounds documented for the rest home and hospital. The wounds included skin tears, chronic ulcers and excoriated skin. The GP had reviewed all chronic wounds. There were two stage I pressure injuries being monitored at the time of audit.  Monitoring charts were in use; examples sighted included (but not limited to): weight and vital signs; blood glucose; pain; nutritional intake; restraint, turning charts; and behaviour monitoring as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities team is led by an experienced activity coordinator with nine years’ experience. The team comprises of a divisional therapist and another activities person. The integrated programme for rest home and hospital level of care residents takes place in both areas. The programme is developed fortnightly and each resident receives a copy of the programme. Noticeboards also alert staff and residents to the daily activity schedule. A wide range of activities were included in the programmes.  The facility has a van which is used for resident outings. The activity coordinator drives the van and an assistant or volunteer accompanies the activity coordinator on resident outings. A number of the residents attend Hukanui Country and Western Club on alternate Saturdays. There are links with local schools and community.  One-on-one time is scheduled for those residents who do not like, or are unable to attend group activities.  On or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six-monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities. There are recreational progress notes in the resident’s file that the activity staff complete for each resident every month. 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 ‘My Day My Way’ care plan and is reviewed at the same time as the care plan in all resident files reviewed.  Families and resident praised the activities provided. Residents from both levels of care were observed to be provided with and enjoying a wide range of activities.  The activities programme is wide and varied. The service provides a 7 day a week activity plan that encompasses all the senses therefore catering for all of our residents needs. Community Engagement is an area they have developed within the Care Home. The activity team stated there has been a ‘snowball effect’ within the home when community groups are introduced and often these groups extend further opportunities for the care home. The service is actively encouraging independence of their residents and due to the small township they are often able to go up town for various reasons. The Tararua Community has also recognised the involvement the Waireka has had. In 2015 they were nominated for the ‘Health and Wellbeing’- Empowering volunteers award at the Trust Power community awards. This award recognises the outstanding contribution to the Tararua District Community. There were placed 3rd.  In 2016, they were nominated for the same award. The community voted and they received the runner-up award. This acknowledgement spurred them onto improving and integrating even more into the community with the support of volunteers. They have a volunteer ‘pool’ of approximately 20 people. These volunteers range in age from 16 years through to 70 years old. The majority of volunteers begin their journey with them when they have family members that are residents there. Often they continue volunteering after the resident has passed away. Their volunteers are also members of various community groups and their links are aided by their involvement |
| 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’ six-monthly. There is a comprehensive multidisciplinary review documented. The multidisciplinary review involves the RN, GP, physiotherapist (if involved in resident treatment) activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.  Written evaluations describe the resident’s progress against the residents identified goals. 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. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident’s condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services. |
| 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 data sheets 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. | FA | A current building warrant of fitness certificate is posted at the entrance to the facility (expiry 11 August 2017).  Reactive maintenance and a 52-week planned maintenance schedule is in place that has been maintained. There is a full-time maintenance person employed who has completed health and safety training. The hot water temperatures are monitored weekly and maintained between 43-45 degrees Celsius. There are contractors for essential services available 24/7.  The corridors are wide with handrails and 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 are well maintained. There is outdoor furniture and shaded areas. There is wheelchair access to all areas.  The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of communal toilets located near the communal areas. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Residents interviewed reported their privacy is maintained at all times.  Privacy locks are installed on all toilet and shower doors. |
| 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. They are spacious enough to manoeuvre transferring and mobility equipment to safely deliver care. Residents are encouraged to personalise their bedrooms as desired. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are lounges in each of the wings. The hospital wing has a dining area with a kitchen servery. In the rest home, the dining room is adjacent to the main kitchen. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this. Seating and space is arranged to allow both individual and group activities to occur. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is done on-site. Laundry and cleaning audits are completed as part of the internal audit programme. The laundry and cleaning rooms are designated areas and clearly labelled. Chemicals are stored in locked rooms. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.  There are dedicated cleaning and laundry staff. Cleaning trolleys are well equipped and stored safely when not in use. Residents and relatives interviewed reported that they were satisfied 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. The last fire evacuation drill occurred on 15 February 2017. Smoke alarms, sprinkler system and exit signs are in place. Supplies of stored water and food are held on-site and are adequate for three days. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting. There are civil defence kits in the facility. Call bells are evident in residents’ rooms, lounge areas and toilets/bathrooms. The facility is secured at night and security patrols are conducted at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has ceiling heating throughout the personal and communal areas. All communal rooms and bedrooms are well ventilated and light. Residents and family interviewed stated the temperature of the facility is comfortable. There is plenty of natural light in resident’s rooms. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Bupa has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The clinical manager is the designated infection control officer with support from the registered nurses and other Bupa infection control coordinators. The IC team meets as part of the quality team meeting to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme. The infection control (IC) officer has maintained their practice by attending infection control updates. The infection control team (the quality team) is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and 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 facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control officer who has completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 officer. Infection control data is collated monthly and reported at the quality meetings. The infection control programme is linked with the quality management programme.  Benchmarking against the other Bupa facilities is completed monthly.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. The facility had an infection (respiratory) outbreak in June 2016. Infection log, staff education, communication with residents and families, short-term care plans and debrief/evaluation of management of the outbreak were evidenced completed. The relevant authorities were evidenced to have been notified of the outbreak. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint policy in place that 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 two residents on restraint (lap belts) and no residents on enablers. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The clinical manager is the restraint coordinator for the facility and has defined responsibilities included the job description. Bupa has a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. Only staff that have completed a restraint competency assessment are permitted to apply restraints. Restraint competencies are completed annually and there is ongoing education including challenging behaviours. Quality and clinical meetings include discussion on restraint. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by the clinical manager or registered nurses in partnership with the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Ongoing consultation with the resident and family/whānau was also identified. Falls risk assessments are completed six-monthly. A restraint assessment form was completed for the two residents requiring restraint (sighted). Assessments consider the requirements as listed in Criterion 2.2.2.1 (a) - (h). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation with the consumer (as appropriate) or family/whānau and the facility restraint coordinator. Overall each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use is used as a last resort in keeping with the Bupa restraint minimisation policy. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation considers the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment for residents on the restraint register and as part of their care plan review. Families are included as part of this review where possible. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. Reduction of restraint is an ongoing target at the facility as they constantly working on the reduction of restraint within the facility every year. The organisation and facility are proactive in minimising restraint. Restraint education and training programme is in place, which includes restraint competencies. |

# 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 1.3.3.3  Each 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 | All resident files sampled contained initial assessments and care plans and long-term care plans that were completed and reviewed within contractual timeframes. Not all interRAI assessments were evidenced to be completed within the required contractual timeframes. Six-monthly multidisciplinary team evaluations were documented on all permanent resident files reviewed.  The resident files identified the GP had seen the resident within two working days of admission and had examined the residents at least three-monthly or more frequently as required for residents of concern. | The interRAI assessment had not been completed within the contractual timeframes in one rest home and two hospital files reviewed. | Ensure that all assessments are completed and reviewed as per contractual requirements.  90 days |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. | Bupa has robust quality and risk management systems and these are implemented at Waireka, supported by a number of meetings held on a regular basis. Quality improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Waireka through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification.  Waireka is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans (CAP) are established when above the benchmark. Toolbox talks are routinely completed that link to benchmarking indicators in each of the two areas at Waireka. Quality action forms are also established for areas that staff/management identifies as requiring improvement and these are evaluated for effectiveness. Waireka has focused on decreasing the number of resident falls by greater than 50%. Strategies have been implemented including utilising tools to provide the causes of falls within the home and ways to minimise causes and put in place routines going forward to continue on-going analysis. In 2016, they saw a steep incline of falls in the rest home from being under the BUPA benchmarking for 2014 at 3.4 (per 1000 bed days), 2015 it increased to 4.9 ( per 1000 bed days) and jumping substantially to 9.6 (per 1000 bed days) which is over the BUPA benchmarking. Falls in the Hospital wing have reduced steadily over the last 3 years, 2014 they were over the benchmarking rate at 9.6 (per 1000 bed days), 2015 they were 9.4 (per 1000 bed days) and in 2016 they were under the benchmark at 5.3 (per 1000 bed days). Evaluations include on-going monitoring and re-evaluating strategies to minimise falls. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Benchmarking reports are generated throughout the year and an annual review of the data is completed. Quality improvement forms are utilised at Waireka and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The service is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. | Waireka is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data collected, the clinical manager feeds back monthly to staff at handover and staff meetings arising and identified trends or issues. Any identified common themes around incidents/infections etc. results in further education, toolbox sessions and meetings. Documentation reviewed identified that strategies are regularly evaluated. Waireka focused on pressure injury prevention in 2016 due to a high number of pressure injuries occurring in 2015.  The service implemented the following strategies that included (but not limited to): (i) Analysis of pressure injury data from 2015, to identify root cause: (ii) Workshop for RNs on pressure injury risk assessments: (iii) Compulsory in-service on pressure area management and hydration and nutrition; (iv) Commencing turn charts and nutrition charts, for those identified at risk. Quarterly progress report reviewed identified YTD that they reduced facility acquired pressure injuries from 23 in 2015 to 12 in 2016. |

End of the report.