

Bupa Care Services NZ Limited - BeachHaven Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	BeachHaven Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Residential disability services - Physical
Dates of audit:	Start date: 29 May 2017 End date: 30 May 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	95

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

Indicator	Description	Definition
	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

BeachHaven is part of the Bupa group. The service is certified to provide hospital (medical and geriatric), psychogeriatric, residential disability -physical and intellectual disability care for up to 99 residents. On the day of audit there were 95 residents. Residents, families and the GP interviewed spoke positively about the service provided.

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

This audit has identified improvements are required around: open disclosure; corrective action plans; education; interventions; and medication management.

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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Residents and families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

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.
---	--	---

A quality management system is documented. Quality and risk information is reported at staff meetings. Residents and family are provided with the opportunity to feedback on issues during resident meetings and via annual satisfaction surveys.

Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. An education and training programme is provided. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing. Registered nursing cover is provided 24 hours a day, 7 days a week. Caregivers, residents and family members report staffing levels are sufficient to meet residents' needs. There are adequate numbers of staff on duty for the residents' care needs.

The residents' files are appropriate to the service type.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

The registered nurses are responsible for each stage of service provision. A registered nurse assesses plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed were individualised and demonstrated service integration. Care plans are evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. The residents and relatives were complimentary about the care received and the services provided at BeachHaven.

Medication policies reflect legislative requirements and guidelines. The service uses an electric medication system. The medicine charts have been reviewed at least three-monthly.

A diversional therapist oversees the activity team and implementation of the activity programme for each unit. The programme includes: community visitors; outings; entertainment; and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Caregivers provide activities for residents in the hospital and psychogeriatric unit.

All meals and baking is done on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menu is reviewed by the dietitian. There are nutritious snacks available 24 hours. Residents and relatives commented positively on the meals provided.

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.
--	--	--

The service has a current building warrant of fitness that expires 26 April 2018.

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 receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had 17 restraints in use and no enablers.

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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	3	2	0	0
Criteria	0	33	0	3	3	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints procedure to guide practice. The care home manager has overall responsibility for managing the complaints process at BeachHaven. There were 12 complaints in 2016 and 6 complaints in 2017 year to date. A complaint management record has been completed for each complaint and a record of all complaints per month has been recorded on the complaint register. The register included relevant information regarding the complaint including date of resolution. Verbal complaints are included and actions and response are documented. The complaints procedure is provided to resident/relatives at entry. Complaint forms were visible for residents/relatives in various places around the facility. Discussion with residents and relatives confirmed they were provided with information on the complaint process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	PA Low	<p>There is an incident reporting policy to guide staff on their responsibility around open disclosure. Relatives interviewed stated they are informed when their family members health status changes. Incident forms reviewed identified that six of nine families had been notified following a resident incident. There is an interpreter policy and contact details of interpreters were available. 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 that is not covered by the agreement. The information pack is available in large print and this can be read to residents. Information specific to the psychogeriatric unit is provided to family on admission.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>BeachHaven is part of the Bupa group of facilities and provides care for up to 99 hospital - geriatric/medical and psychogeriatric (PG) care across three units. On the day of audit there were 95 residents. There were 56 psychogeriatric residents, 36 hospital residents and 3 residents admitted under a long-term chronic agreement.</p> <p>The East wing (hospital) has 25 residents in the 27 hospital beds -including 1 resident admitted under a long-term chronic agreement and 3 psychogeriatric residents. Tui unit (PG) has 32 residents in the 32 beds. The Tui unit is divided into two separate units a sixteen-bed mixed wing and a sixteen-bed female only wing. There was one resident admitted under a long-term chronic agreement in the female only wing. Kowhai is a secure hospital unit. The Kowhai unit has 38 residents in the 40 hospital beds (15 assessed at hospital level, 22 assessed as psychogeriatric level of care and 1 resident admitted under a long-term chronic agreement). Of the 15 assessed at hospital level of care, 3 were mobile and had been assessed for environmental restraint. The DHB are aware of the secure hospital unit that includes a combination of hospital and PG residents. The manager advised that all residents within this unit have some form of dementia and behaviours that challenge and require a secure environment. The East wing had push button entry and exit that was accessible. A hospital resident and relative were observed being able to exit through the door.</p> <p>The service is also certified to provide residential disability–intellectual and physical level care. There are no residents currently under MOH disability contracts.</p> <p>The philosophy of the service includes providing safe and therapeutic care for residents requiring specialised dementia care (PG) and hospital care. There is an overall Bupa business plan and risk management plan and a documented purpose, values and direction. Each facility is required to develop annual quality goals – BeachHaven for 2017 is focusing on two health and safety goals and two clinical goals. Progress towards achieving the goals is reported through the various meeting (e.g., the quality meeting, full staff and clinical meetings). BeachHaven participates in the organisations benchmarking programme that monitors key aspects of care.</p> <p>The care home manager at BeachHaven is an experienced manager (RN) with a current practising certificate and has an aged residential care background. She is supported by a clinical manager (registered nurse) who oversees clinical care and has been in the role for many years. The management team is supported by the wider Bupa management team that includes an operations manager. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six-monthly. The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.</p>
Standard 1.2.3: Quality And Risk	PA Low	A quality and risk management programme is documented. Interviews with staff (the care home manager, clinical manager, five registered nurses, four care staff, three activities staff, clinical advisor, one cook and one office

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>manager) reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>An internal audit programme is being implemented as per the Bupa audit schedule. However, not all audits were rescheduled where the audit results were below the company benchmark. Areas of non-compliance include the initiation of corrective actions, however not all corrective actions implemented were documented. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions. Staff interviewed advised that quality data is placed on noticeboards in staff areas (sighted).</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (clinical advisor) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review January 2017).</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. This has included: identifying the residents that are a high falls-risk; the use of hip protectors and hi/lo beds; assessment and exercises by the physiotherapist; landing strips by beds; sensor mats; and perimeter mattresses (link 1.3.6.1)</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau</p>	<p>FA</p>	<p>Incident/accident forms are completed by staff that either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at time of the event. Care plan interventions following an adverse event were not updated for residents with behaviours, restraint and bruising. Not all required monitoring for behaviours or unwitnessed falls, had been documented (link 1.3.6.1). The incident/accident reports sampled demonstrated the events had also been documented in the residents' progress notes. Families were not consistently advised of adverse events (link 1.1.9).</p> <p>Discussions with the care home manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>

of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed, (one clinical manager, one unit coordinator, two caregivers, one hospitality manager, one cook and one diversional therapist) included a recruitment process, signed employment contracts, job descriptions, performance reviews and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN and support staff) and includes documented competencies. New staff are buddied for a period of time (e.g., caregivers- two weeks and RN- four weeks); during this period, they do not carry a clinical load. Completed orientation booklets were on staff files. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service.</p> <p>There is an annual education schedule, that exceeds eight hours annually, that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. There are implemented Bupa competencies for staff, however not all staff had completed the required annual competencies. There is an RN training day provided through Bupa that covers clinical aspects of care (e.g., dementia and delirium). External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training.</p> <p>Sixteen of nineteen RNs have completed their interRAI training.</p> <p>Thirty-five of thirty-eight caregivers and all activities staff that work across the PG units have completed the required dementia standards.</p> <p>There is a minimum of one care staff with a current first aid certificate on every shift.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.</p> <p>Across the two Kowhai wings (secure hospital with 15 hospital, 22 PG and 1 long-term chronic), there are two RNs rostered on the morning shift (plus seven caregivers- five long and two short) and a unit coordinator (RN); two RNs on afternoon shift (plus five caregivers- two long and three short) and one RN at night (plus two caregivers).</p>

<p>and/or experienced service providers.</p>		<p>In Tui wings (with 31 of 32 PG residents), there is one RN across each shift and a unit coordinator (RN) in the morning. On a morning shift, there are six caregivers- four long and two short. On an afternoon, there are four caregivers- two long and two short and one caregiver on nights.</p> <p>In East wing (with 21 hospital, 1 long-term chronic and 3 PG in the 27 hospital beds), there is a unit coordinator (RN), another RN or clinical assistant in the morning and an RN on an afternoon shift. There is an EN on five nights per week. On a morning shift, there are six caregivers- three long and three short. On an afternoon, there are five caregivers- two long and three short. There is one caregiver on nights Monday to Friday and two caregivers on nights over the weekend.</p> <p>Interviews with caregivers across all areas confirmed that staffing levels were good and that staff work well as a team.</p> <p>Interviews with five relatives (four PG and one hospital) all stated that there was always staff around and they felt staffing numbers were sufficient to meet the needs of the residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, ENs and caregivers) are required to complete medication on an annual basis, however this has not been completed for four staff. RNs have completed syringe driver training (link 1.2.7.3). Education around safe medication administration has been provided annually. Robotic sachets are used for regular medications and bottles for 'as required' medications. There is evidence of medication reconciliation on delivery of medications. All eye drops have been dated on opening. Medication fridges are checked daily and corrective actions have been documented for any temperatures outside of the acceptable range. All eye drops were dated on opening. There were no self-medicating residents. The standing orders used are non-compliant. Not all medications were stored safely as creams and lotions were sighted on bedside tables and in a bathroom.</p> <p>The service introduced an electronic medication system in February 2017. Medication chart prescribing meets legislative requirements. Twelve medication charts reviewed (six hospital and six psychogeriatric) had photo identification and allergy status documented on the chart. The GP or psychogeriatric team monitor the use of antipsychotic medication. Medications charts evidenced three-monthly GP review. Oxygen had been administered once without a prescription and was not on the standing orders.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	<p>FA</p>	<p>All meals and baking are prepared and cooked on-site by the cook. The cook is supported in the morning and in the afternoon by kitchen hands. Food services staff have attended food safety training. The four-weekly seasonal menus have been reviewed by the organisational dietitian. Meals are delivered in bain maries to each unit where meals are served by staff.</p> <p>The cook receives a resident dietary profile for new residents and is notified of any dietary changes. Likes and</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>dislikes are known. Special diets are accommodated including diabetic desserts, soft and purred diets and vegetarian. The cook is notified of any resident's dietary changes and weight loss. Protein drinks and fluids and nutritious snacks are available 24 hours in the units.</p> <p>Fridge, freezer and end cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the kitchen and facility kitchenette fridges were dated. The dishwashers are checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals are stored safely. A cleaning schedule is maintained.</p> <p>Direct input from residents and relatives provide feedback on the meals and food services generally. Residents and/or family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. Overall there was documented evidence that family members were notified of any changes to their relative's health status (link 1.1.9.1). Discussions with families were recorded on the family/whānau contact sheet, in the resident files reviewed. Short-term care plans were in place for wounds and skin tears. Short-term care plans are available for use for short-term cares. Not all interventions had been implemented or documented to meet the resident needs/supports.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for seven psychogeriatric residents and two hospital residents. There were no residents with pressure injuries on the day of audit. The service has access to the district nurse or wound nurse at the DHB.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT) to oversee the activity team of three (one DT and two activity assistants with dementia unit standards), who provide activities from 8.30am to 3.30pm Monday to Friday. A diversional therapist provides activities in each of the units on the weekends. The team rotate units monthly. The units have separate programmes which are flexible and accommodate differing abilities and one-on-one activities. Activities include (but not limited to): walks; sensory activities; craft; music; bingo; cooking; exercises; ball and balloon games; bowls; and floral art. Music and entertainers visit the units. A pet dog visits the facility twice-weekly for the day. Church services are held monthly and a lay preacher provides weekly communion. There are regular van trips for all residents.</p> <p>Caregivers on duty incorporate resident small group and individual activities as part of their duty. Individual participation records are maintained. Caregivers interviewed were able to describe how they met the resident's</p>

service.		<p>individual recreational preferences. Activities were observed in the units on the days of audit.</p> <p>An activity assessment is completed on admission. Socialising and activities is included in the 'My Day, My Way' care plan. The service receives feedback and suggestions for the programme through surveys and resident/relative meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. The long term care plans had been reviewed by the multidisciplinary team (MDT) at least six-monthly or earlier for any health changes in five of six resident files. One psychogeriatric resident has not been at the service six months. Family are invited to attend the MDT review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Written evaluations are completed and reflect if the resident/relative (as appropriate) goals have been met or unmet.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is posted in a visible location (expiry 26 April 2018). Preventative and reactive maintenance occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Where opportunities for improvements have been identified, corrective actions have been implemented, but these actions have not always been documented (link 1.2.3.8). Infection control internal audits have been completed. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There has been one outbreak since the previous audit and this was well managed. Systems are in place that are appropriate to the size and complexity of the facility.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>On the day of audit there were no residents using enablers. There were 17 restraints in use on the day of audit including 3 mobile residents with consented environmental restraint. Three of four restraint files reviewed did not document risks associated with the use of restraint (link 1.3.6.1).</p>
--	-----------	--

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	In the resident files sampled, there was evidence of regular communication with families and family involvement in the development and review of the long-term care plan. The accident and incident form in use has a section to record if families are notified of an adverse event (or not). In three of nine incident forms reviewed, there was no evidence that families had been advised of an adverse event and contact with family was not noted in the progress notes.	Three of nine incident and accident forms reviewed (psychogeriatric) did not evidence that family were notified of the adverse event.	Ensure that families are advised of all adverse events unless families have indicated otherwise. 90 days
Criterion 1.2.3.8	PA Low	The service captures quality	Corrective action plans are being implemented but not	Ensure that the

<p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>		<p>data. Where areas requiring improvements were noted (infections, skin tears, behaviours, bruising and medication incidents), corrective actions were initiated as described by staff, however not all corrective actions were documented.</p> <p>The Bupa audit schedule is being implemented, however not all audits with low results (e.g.: activities, restraint, multidisciplinary reviews, care planning and medication) were re-audited to determine the effectiveness of corrective actions</p>	<p>consistently documented where the quality data is identifying areas requiring improvement.</p> <p>Not all audits with low results (e.g.: activities, restraint, multidisciplinary reviews, care planning and medication) were re-audited to determine the effectiveness of corrective actions</p>	<p>corrective actions implemented are documented where opportunities for improvement are noted.</p> <p>Ensure internal audits are re-audited following corrective actions where results are below expected percentage</p> <p>90 days</p>
<p>Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>The service has a robust process in place to reference check all new staff and obtain and keeps on files, copies of practicing certificates for all staff that require these. The service has a robust orientation programme which includes the completion of role specific competencies. Not all staff could evidence completion of the required annual organisational competencies. Three caregivers who have worked at the service for longer than 12 months have not completed the required dementia standards training.</p>	<p>i) Three of thirty-eight caregivers who have been at the service longer than twelve months, have not completed the required dementia standards. Two are in progress and one who has been employed since 2010 has not yet started.</p> <p>ii) Annual competencies could not be evidenced for all staff that require competencies in relation to: manual handling; nebuliser use; oxygen usage; peg feeds; restraint; subcutaneous fluids; and syringe drivers.</p>	<p>i-ii) Ensure that all staff who work at the service have completed the training and annual competencies required to meet all organisational contractual and legal requirements.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>An electronic medication system is used. Prescribing meets legislative requirements including indications for use of 'as required' medication. Medication charts are reviewed at least three-monthly. All oral and subcutaneous medications are stored safely, however creams and lotions were sighted in resident rooms and bathroom.</p>	<p>i) Creams and lotions were sighted on three bedside cabinets (one in East wing – hospital and two in Tui – psychogeriatric unit) and in one bathroom (East wing – hospital); and (ii) One hospital resident had been administered oxygen in an emergency. The policy was followed. However, Oxygen had not been prescribed or on the standing orders.</p>	<p>(i) Ensure all medications are stored safely; and (ii) Ensure oxygen is prescribed as required prior to administration.</p> <p>30 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>Staff are required to complete annual medication competencies including administration of insulin and subcutaneous injections. Not all staff administering medications have completed a medication competency. The clinical manager who assesses all staffs' medication competencies, has no documented evidence of completion of a medication competency.</p>	<p>Annual medication competencies have not been completed for the clinical manager, one RN (completed on day of audit), one enrolled nurse and one senior caregiver.</p>	<p>Ensure annual medication competencies are completed and the person assessing medication competencies has also completed the required competency assessments.</p> <p>30 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Monitoring occurs for: weight; vital signs; blood sugar levels; pain; challenging behaviour; repositioning charts; food and fluid; restraint; and visual checks. However, not all monitoring and interventions had been put in place post incidents or for changes to resident health status.</p>	<p>(i) Falls prevention strategies documented for three residents (one hospital and two psychogeriatric) did not reflect the assessed high falls risk; (ii) Monitoring forms had not been implemented following accident/incidents for three psychogeriatric residents (two for behaviours and one for two-hourly turns); (iii) There had been no RN follow up post 'found medication' error for one psychogeriatric resident; (iv) Interventions had not been updated for one hospital resident – long term chronic health condition, to meet the increasing needs for declining mobility and assistance with meals; (v) There were no interventions implemented for one psychogeriatric resident with 5.8% weight loss over two months; and (vi) Two residents on restraint did not have any restraint risks documented and another resident on restraint did not have the use of restraint identified in the care plan.</p>	<p>(i) Ensure falls risk strategies reflect the level of falls risk; (ii) Ensure monitoring forms are implemented as per accident/incident corrective action plans; (iii) Ensure 'medication found' errors are investigated and recommendations implemented; (iv) and (v) Ensure interventions are documented and implemented for changes in health status. (vi) Ensure restraint risks are interventions are documented.</p> <p>60 days</p>
---	------------------------	--	--	--

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, there 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.