**Bupa Care Services NZ Limited - Te Whanau Rest Home & Hospital**

**Current Status:** **03-Jul-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Te Whanau rest home and hospital is part of the Bupa group. The service is certified to provide hospital (geriatric and medical) and rest home level care for up to 65 residents. On the day of the audit there were 37 hospital residents, and 17 rest home residents. Te Whanau is managed by a registered nurse, who has been in the management role for three years. She is also supported by a clinical manager, and a Bupa operations manager. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised at well-established at Te Whanau. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service is commended for achieving seven continual improvement ratings relating to good practice, quality initiatives/governance, implementation of quality initiatives, management of clinical indicators, quality actions as a result of incident reporting, restraint minimisation and infection surveillance.

There is one improvement required around the controlled drug register.

**Audit Summary AS AT** **03-Jul-13**

Standards have been assessed and summarised below:

**Key**

| **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 |

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| **Consumer Rights** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

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| **Organisational Management** | Day of Audit  03-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Continuum of Service Delivery** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

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| **Safe and Appropriate Environment** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  03-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Infection Prevention and Control** | Day of Audit  03-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **All standards applicable to this service fully attained with some standards exceeded** |

**Audit Results AS AT** **03-Jul-13**

**Consumer Rights**

Te Whanau endeavours to provide care in a way that focuses on the individual residents' quality of life. Bupa has introduced an initiative "personal best" whereby staff undertake a project to benefit or enhance the life of a resident(s). Te Whanau have a number of staff involved in the programme. Residents and relatives spoke positively about care provided at Te Whanau. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. A continuous improvement has been awarded against best practice.

**Organisational Management**

Te Whanau has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Te Whanau is benchmarked in two of these (rest home and hospital). The robust systems for quality and risk management are continually being reviewed at both an organisational level and at Te Whanau. Benchmarking and audit data demonstrate that they have achieved good standards of care and service. Quality actions have resulted in a number of quality improvements for both residents and staff. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering. Continuous improvement ratings have been awarded around the implementation of the quality system and education programme.

**Continuum of Service Delivery**

The service has comprehensive admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Lifestyle plans demonstrate service integration. Lifestyle plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around one aspect of medication management. The activities programme is facilitated by activities officer. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis.

**Safe and Appropriate Environment**

The building holds a current warrant of fitness. Rooms are individualised and spacious. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are spacious lounges within each area. There are adequate toilets and showers for the client group. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. All key staff hold a current first aid certificate. Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The facility has gas fired central heating and temperature is comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference.

**Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The service has two residents assessed as requiring restraint and four with enablers. A register is completed for each restraint and this includes three monthly evaluation.

Restraint assessments are based on information in the care plan, discussions with residents and/or families and on staff observations of residents. Restraint is reviewed for each individual at least three monthly and as part of the six monthly multidisciplinary review. Reviews include family/whanau. Restraint usage throughout the organisation is monitored and benchmarked. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly. A continuous improvement has been awarded for their proactive approach to minimising restraint.

**Infection Prevention and Control**

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is responsible for coordinating/providing education and training for staff. Infection control training is provided at least twice each year 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 co-ordinator 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 on-going training in infection control. A continuous improvement has been awarded around the infection surveillance programme and implementing quality improvements to minimise infections.

**Te Whanau Rest Home & Hospital**

Bupa Care Services NZ Limited

Certification audit - Audit Report

Audit Date: 03-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Bupa Care Services NZ Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Te Whanau Rest Home & Hospital | 603 Queen Street |  | Levin |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 03-Jul-13 **End Date:** 04-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | RCompN, Health audit cert | 13.00 | 6.00 | 3-Jul-13 to 4-Jul-13 |
| Auditor 1 | XXXXXXX | RN, Health audit cert | 13.00 | 5.00 | 3-Jul-13 to 4-Jul-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX |  |  | 1.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 26.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 38.00 |
| **Staff Records Reviewed** | 8 of 62 | **Client Records Reviewed** *(numeric)* | 8 of 54 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 12 of 62 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 11 of 54 | **Number of Medication Records Reviewed** | 16 of 54 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 31 day of July 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

**Services and Capacity**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Te Whanau Rest Home & Hospital | 65 | 54 | 10 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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**Executive Summary of Audit**

*General Overview*

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There is one improvement required around the controlled drug register which was addressed on the day of audit.

*1.1 Consumer Rights*

Te Whanau endeavours to provide care in a way that focuses on the individual residents' quality of life. Bupa has introduced an initiative "personal best" whereby staff undertake a project to benefit or enhance the life of a resident(s). Te Whanau have a number of staff involved in the programme. Residents and relatives spoke positively about care provided at Te Whanau. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. A continuous improvement has been awarded against best practice.

*1.2 Organisational Management*

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*1.4 Safe and Appropriate Environment*

The building holds a current warrant of fitness. Rooms are individualised and spacious. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are spacious lounge's within each area. There are adequate toilets and showers for the client group. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. All key staff hold a current first aid certificate. Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The facility has gas fired central heating and temperature is comfortable and constant and able to be adjusted in residents rooms to suit individual resident preference.

*2 Restraint Minimisation and Safe Practice*

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The service has two residents assessed as requiring restraint and four with enablers. A register is completed for each restraint and this includes three monthly evaluation.

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*3. Infection Prevention and Control*

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is responsible for coordinating/providing education and training for staff. Infection control training is provided at least twice each year 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 co-ordinator 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 on-going training in infection control. A continuous improvement has been awarded around the infection surveillance programme and implementing quality improvements to minimise infections.

**Summary of Attainment**

* 1. ***Consumer Rights***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | CI | 1 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:0 CI:1 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:1 FA:22 PA:0 UA:0 NA: 0 |

* 1. ***Organisational Management***

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | CI | 1 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | CI | 2 | 6 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | CI | 1 | 1 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:3 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:4 FA:18 PA:0 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 11 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:20 PA:1 UA:0 NA: 0 |

* 1. ***Safe and Appropriate Environment***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | CI | 1 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:1 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:1 FA:8 PA:0 UA:0 NA: 0 |

1. ***Infection Prevention and Control***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | CI | 1 | 1 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 0 CI:1 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:1 FA:8 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 0 **CI:** 6 **FA:** 43 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 7 **FA:** 93 **PA:** 1 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:03-Jul-13 End Date: 04-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  Controlled medications were evidenced documented in the controlled drugs register. However, controlled drugs prescribed and packaged for individual residents were not documented on individual pages. All controlled medications of the same name and strength were evidenced recorded collectively under the drug of same name and strength of medication. Weekly checks of stock balance were evidenced completed by the clinical manager and an registered nurse.  **Action:**  Ensure that controlled medications prescribed and dispensed by pharmacy for individual residents are documented on an individual page in controlled drug register with residents name and strength of medication immediately. This was addressed on the day of audit and the service provided evidence that all individual residents had individual pages in the Controlled Drugs register | 1 month. |

**Continuous Improvement (CI) Report**

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:03-Jul-13 End Date: 04-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| **Std** | **Criteria** | **Evidence** |
| 1.1.8 | 1.1.8.1 | **Finding:**  Bupa has robust quality and risk management systems and these are implemented at Te Whanau supported by a number of meetings held on a regular basis including (but not limited to); quality, staff, falls focus, restraint, residents, qualified nurses, kitchen and health and safety. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes have been implemented at Te Whanau. Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. A residents/relatives association was also initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Te Whanau - 74.5% of staff have attained bronze, 49% silver and 27.5% have achieved gold. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care. Benchmarking results are provided and reviewed at Te Whanau. 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 Te Whanau through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting. Te Whanau is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. eg: Falls above KPI in Jan 13. Recommendations were also reviewed through the falls focus committee and the effectiveness of actions established were reviewed from Dec 12. A QI corrective action plan April 13 was established for pressure areas in the hospital. These were evaluated, no further pressure areas identified May/June. Quality action forms are also established at Te Whanau for areas that staff/management identify as requiring improvement.  The following have been established (but not limited to); Reduce the number of falls our residents have, managing behaviours that challenge and implementation of palliative care(LCPs), and reduce the amount of medication errors. Toolbox talks are routinely completed that link to benchmarking indicators at Te Whanau. Actions are progress monitored and evaluated for effectiveness. |
| 1.2.1 | 1.2.1.1 | **Finding:**  Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Te Whanau is part of the central Bupa region which includes 10 facilities. The managers in the region meet four monthly, senior managers mentor and provide guidance to new managers. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Te Whanau and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Te Whanau annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Te Whanau has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans were rolled out in end 2011. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. The organisation has commenced a Clinical Governance group. The committee is to continue meeting two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Te Whanau management team interviewed described some of their focused improvements that link to organisational goals including; they have implemented person centred care plans, and an efficient system to ensure that care plans are completed within the six month time frame. They have a part time training co-ordinator whom supports staff completing career force qualifications and foundation skill orientation, as well as PDRP for qualified nurses. |

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| 1.2.3 | 1.2.3.6 | **Finding:**  There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Te Whanau is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of meetings and discussion with the management team, there continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established on a regular basis where Te Whanau is above the benchmark. i.e.: Jan 2013 - falls were high as a result a CAR was established which included an analysis of falls to identify trends/common themes, also a separate analysis for one resident that included initiating corrective actions for one resident that had nine falls (six being in the pm shift). Cognitive issues identifies as a cause of falls, tracking of frequent fallers and evaluation by the falls focus group. While falls continue to remain high in the hospital, the falls focus group and service continue to provide training to staff and residents and identify trends. Te Whanau has taken on board the Bupa drive for reduction in the use of anti-psychotics with their residents and on-going evaluation of effectiveness of anti-psychotics for those prescribed. Other improvements noted include (but not limited to); Falls prevention - they have identified falls prevention champions that are working toward educating other staff and residents, vitamin D programme to prevent fractures sustained during falls. This is to support their goal to reduce falls. Liverpool Care Pathway –this was rolled out the end of 2010 and has improved care at the end of life for our residents. |
| 1.2.3 | 1.2.3.7 | **Finding:**  The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12 month period . Quality action forms are utilised at Te Whanau and document actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, e.g. quality meeting, resident and staff meeting. Te Whanau has two monthly quality and risk management meetings and includes progress to meeting their annual quality goals.  The quality goals identified at Te Whanau for 2012 include documented quarterly progress and evaluation. Progress is forwarded to the quality management coordinator for Bupa. The Facility Manager provides a documented weekly report to Bupa Operations Manager. The Operations Manager visits monthly and completes a report to the GM. The service completed regular progress reporting and implemented on-going corrective action plans to meet their 2012 goals; In 2012 Te Whanau set three Quality goals, one was in line with the Bupa Bfit programme which has been carried over as a goal for 2013 under Health & Safety; the second was to reduce restraint usage in their facility, and the third to review and improve our activity programme. The service described a number of activities completed during the year for their BFit Programme; including (but not limited to)f, “Biggest Loser” Challenge, this was run by staff and several staff members made significant lifestyles changes and lost weight. They managed to achieve their goal and reduce restraint usage by more than 50% (link 2.2.5). The service identified other improvements implemented from quality initiatives including; changing their drug charts moving to pharmacy generated so that the charts are clearly able to be read and consistent; quarterly Te Whanau newsletter for residents and family provided. Also they have secured an independent person to facilitate Residents/family & friends meetings, starting July 2013. The management team stated that they have strengthened palliative care with staff completing fundamentals of Palliative, a supportive relationship with Arohanui Hospice and the Palliative Resource network group established. |

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| 1.2.4 | 1.2.4.3 | **Finding:**  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and qualified staff meeting reflect a discussion of benchmarking results. The incident/infection analysis tool and quality indicator corrective action plan is well utilised at Te Whanau to assist with analysis and plan improvements to service delivery. There is a number that have been implemented to date across 2013 when benchmarking results are above the normal. For eg: bruising was up in March in the hospital, a CAP was completed which resulted in an analysis of the incidents to identify trends. This was shared with staff at hand-over, tool box talks provided that included manual handling and how to prevent. Corrective actions evaluated identified that all clients with bruising in March now use leg protectors and have been adjusted to their care plans. Bruises reduced April, May. |
| 2.2.5 | 2.2.5.1 | **Finding:**  Individuals approved restraint is reviewed at least three monthly through the restraint meeting and as part of six multi dip review with whanau involvement. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at Regional Restraint Approval groups. The organisation and facility are proactive in minimising restraint. Bupa analysis for 2012 has been shared with the restraint coordinators across the organisation. The organisation started the year off with a rate of 2.9 (269 people being restrained) and finished on 2.7 (254 people being restrained). No-one has been restrained in any rest home unit since April 2011. Hospital rate of restraint reduced over 2012 from 5.4 down to 4.8. In dementia, three care homes using restraint at some point – however by December , back to nil again . There have been mixed results in psycho-geriatric where the rate actually increased over the year from 5.8 to 6.0. There are now 12 care homes that have maintained a restraint free environment during the year (26%) restraint free. In January 2009 they had 502 residents (rate of 5.7) restrained across all care homes and types, at the end of December 2012 they had 254 residents (rate of 2.7) restrained. Over four years this is a reduction of 49% in raw numbers. Te Whanau restraint usage has come down since the last audit . With a strong drive to implement other measures and use restraint as a last resort they have gone from 85% bedrails and 15% lap belts in hospital 2011 to 45% in 2012 and 3% in 2013. They have worked hard to maintain this status through three monthly meetings, regular falls risk assessments of residents, implementation of the falls focus committee, assessments by physiotherapists, regular training and staff competencies. A facility restraint report has been completed annually that analysed restraint-use across the year. |
| 3.5.7 | 3.5.7 | **Finding:**  The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. Infection control (IC) stats are discussed at qualified staff and IC meetings and corrective actions are implemented when infections increase. Incident/infection - analysis tool is utilised to assist with identifying trends. In May 13 an increase in respiratory tract infections and UTIs (six hosp/two rest home) resulted in two QIPs being developed. QIPs included analysis of current management plans, review of effectiveness and on-going observations as per STCPs. Toolbox talks provided to staff included (but not limited to); UTIs in June 13. Corrective actions implemented resulted in decrease in UTIs and RTIs in June 13. Infection stats, trends and education are regularly provided via noticeboards and meetings to staff, residents and relatives. |

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and COR competency questionnaires. Interviews with six caregivers across all morning and afternoon shifts (four hospital, two rest home) showed an understanding of the key principles of the code of rights. Training provided March 13 (7 attended). A Code of rights knowledge questionnaire was also completed by staff Jun 13 (100%)

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. Information is also given to next of kin or EPOA to read and discuss to or with the resident in private. On entry to the service, the manager/clinical manager discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available around the facility. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Interviews with residents (five hospital, six rest home) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

The clinical manager speaks mandarin and communicates/translates for the one resident that doesn’t speak English.

Interviews with five relatives (one rest home, four hospital) confirmed they are informed of the code of rights and this is also discussed at resident/relative meetings.

D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The confidentiality and resident privacy policy states the manager is the privacy officer. Privacy and communication training was Feb 13. During the tour of the facility respect for privacy and personal space was demonstrated. Resident files are held in the combined rest home/hospital locked nurses’ office. Interview with caregivers (two rest home, four hospital) could explain ways resident privacy is maintained. Interviews with 11 residents confirmed that privacy is ensured. The Feb 2013 resident satisfaction survey identified that 95% resident’s stated privacy was either excellent or good.

Resident information includes Bupa vision and values. Discussions with residents (six rest home, five hospital ) and five hospital relatives were positive about the service in respect of considering and being responsive to meeting values and beliefs.

D4.1a Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery. An initial care planning meeting six weeks after admission is carried out, whereby the resident/family are invited to be involved - cultural/religious would be again considered at this time.

Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, meal times and meal alternatives) and that staff are obliging around choice. Care plans reviewed identified specific individual likes and dislikes. Caregivers from across the morning and afternoon shifts could describe examples of giving residents choice including, what time they would like to get up and go to bed, if they would like a shower or not, what they would like to wear and choices about food and activities. There is a question around 'choice' in the Feb 2013 resident satisfaction survey, 84% of residents stated excellent or good.

A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training is completed annually and last delivered in March 2013 ( 12 staff attended).

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Person centred care/individuality and independence training is provided to staff annually (last Feb 12 - 15 attended).

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa’s facilities. The CDHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Te Whanau has an attachment to the policy that relates specifically to their area. Local Iwi and contact details of tangata whenua are identified. Special events and occasions are celebrated at Te Whanau and this could be described by staff. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process. There are currently two residents that identify as Maori in the hospital. One Maori file reviewed of resident that identified as Maori included cultural consideration/needs and involvement of whanau. One resident interviewed confirmed support and consideration by staff.

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member’s stay/care.

**Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete ' the map of life'. Discussions with five hospital relatives all identified that values and beliefs were considered. Discussion with six rest home and five hospital residents all stated that staff took into account their culture and values.

D3.1g: The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment, planning process and interviews with residents confirmed that cultural values and beliefs were considered and discussed during review of the care plan.

D4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.

**Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. The enrolled nurse works under the direction and supervision of registered nurses. The enrolled nurse EN has transitioned to the Nursing Councils new scope of EN practice and is currently working towards completing her Bupa PDRP.

There is policy to guide staff practice: Gift, Gratitude’s and Benefits, Delegations of Authority. Qualified nurses meeting (bimonthly) includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. The code of conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. Interviews with one registered nurse described professional boundaries.

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** CI

Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Te Whanau is currently benchmarked in two areas (hospital and rest home). A quality improvement programme is implemented that includes performance monitoring.

A2.2 Services are provided at Te Whanau that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for care workers, enrolled nurse and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

The service is commended for achieving a continued improvement rating at a service level and organisational level through the implementation of on-going quality improvements, focus on improving clinical indicators, on-going training and mentoring.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Across Bupa, four benchmarking groups are established for Rest Home, Hospital, dementia, and Psychogeriatric/Mental Health services and benchmarking data is available at Te Whanau. The service is currently benchmarked in two areas (hospital and rest home).

Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. Benchmarking data supports initiative development and there was a number at Te Whanau where Quality Indicator Corrective Action Plans have been established due to benchmarking being above the expected i.e.: raised KPI for increased skin tears in the hospital April 13. Action plan established which included progress and evaluation and involved toolbox talks to staff.

A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies.

There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.

Standardised annual education programme, core competency assessments and orientation programmes have been implemented at Te Whanau. D17.7c.There are implemented competencies for care workers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. Competencies are completed for key nursing skills at Te Whanau including (but not limited to); a) hoist/ manual handling, b) wound care, c) sub cut fluids, d) assessment tools, e) medications including nebulisers, BSLs/insulin, oxygen admin, syringe drivers, f) PEG feeds, catheter - female and male and g) first aid. RNs have access to external training. One registered nurse at Te Whanau is a Career Force assessor, and two are preceptors.

A residents/relatives association was also initiated in 2009, in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group of which also involves from the exec team the CEO, GM Quality and Risk and Consultant Geriatrician currently meets every three months.

Discussions with six rest home, five hospital residents and five hospital relatives were positive about the care they receive. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s).

A2.2 Services are provided at Te Whanau that adhere to the health & disability services standards. There is an implemented quality improvement that includes performance monitoring.

D1.3 all approved service standards are adhered to.

**Finding Statement**

Bupa has robust quality and risk management systems and these are implemented at Te Whanau supported by a number of meetings held on a regular basis including (but not limited to); quality, staff, falls focus, restraint, residents, qualified nurses, kitchen and health and safety. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes have been implemented at Te Whanau. Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. A residents/relatives association was also initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Te Whanau - 74.5% of staff have attained bronze, 49% silver and 27.5% have achieved gold. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care. Benchmarking results are provided and reviewed at Te Whanau. 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 Te Whanau through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting. Te Whanau is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. eg: Falls above KPI in Jan 13. Recommendations were also reviewed through the falls focus committee and the effectiveness of actions established were reviewed from Dec 12. A QI corrective action plan April 13 was established for pressure areas in the hospital. These were evaluated, no further pressure areas identified May/June. Quality action forms are also established at Te Whanau for areas that staff/management identify as requiring improvement. The following have been established (but not limited to); Reduce the number of falls our residents have, managing behaviours that challenge and implementation of palliative care (LCPs), and reduce the amount of medication errors. Toolbox talks are routinely completed that link to benchmarking indicators at Te Whanau. Actions are progress monitored and evaluated for effectiveness.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.

The one registered nurse and clinical manager interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for June identified that all 19 incident forms, identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was last completed in April 2013 at Te Whanau with a result of 99%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b All five hospital relatives interviewed stated that they are always informed when their family members health status changes.

A residents/relatives association was initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician.

In September 2009 Bupa NZ welcomed the appointment of a communications manager to the group. This person's role is to keep people informed and engaged about Bupa NZ’s strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.

Interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and Government Agencies is available. In addition there is a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available.

D12.1 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

D16.1b.ii 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. 'D11.3 The information pack is available in large print and advised that this can be read to residents.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are procedure information sheets available including (but not limited to); a) minor skin surgery, b) catheterisation, and c) sub cut fluids.

Required consent forms and advance directive forms were evident on eight resident files reviewed.

Discussions with six caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with one registered nurse and clinical manager identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

There is an advance directive policy. The Bupa care services resuscitation of resident’s policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The “decisions relating to cardiopulmonary resuscitation” pamphlet and advance directive form will be given to the resident and completed. The medical resuscitation treatment plan and resuscitation advance directive will be completed as soon as possible after admission (no more than six weeks).

Completed resuscitation treatment plan forms were evident on all eight resident files reviewed. Medical notes evidence discussion with family where appropriate.

D13.1 there were eight admission agreements sighted and all had been signed on the day of admission.

D3.1.d Discussion with five family identified that the service actively involves them in decisions that affect their relatives lives.

**Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with three registered nurses described how residents are informed about advocacy and support. A resident advocate facilitates the two monthly resident meetings in the rest home and hospital.

Interviews with six rest home, five hospital residents confirmed that they are aware of their right to access advocacy.

D4.1d; discussion with five family identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e,: Resident files reviewed included information on residents family/whanau and chosen social networks.

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Visitors were observed coming and going during the audit. There is a family/whanau - participation and contact policy. The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. D3.1.e: Interviews with six rest home, five hospital residents confirmed that the activity staff help them assess the community such as go shopping. The following 'Personal Best' examples were provided in regards to accessing the community, escorting residents to the races, ballet and shopping, taking residents on social outings and one on one walks.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Complaints received each month are reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with six rest home, five hospital residents and five hospital relatives confirmed they were provided with information on complaints and complaints forms. 2013 YTD complaints were reviewed and included three written complaints. All were well documented including investigation, follow up letter and resolution.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** CI

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Te Whanau has set specific quality goals for 2013 including (but not limited to); a) decrease falls by 2%, b) reduce medication incidents, c)Improve staff completion of Personal Best and Career force core competencies and d) Refurbish hair dressers to improve the residents experience.

Bupa Te Whanau provides hospital - medical, geriatric, and rest home level care for up to 65 residents. There were 17 of 18 rest home residents, 37 of 46 hospital residents. The service has 10 rest home rooms approved as swing beds. There are three young people with disabilities (YPD) residents, two under ACC and one palliative care under the medical component of their certificate.

The organisation has commenced a Clinical Governance group. The committee is to continue meeting two monthly. The aim is to review the past and looking forward. Specific issues identified in Health and Disability Commissioner’s (HDC) reports (learning’s from other provider complaints) are also tabled at this forum.

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10.

Te Whanau Facility Manager (RN) has been in the role since March 13, previously she was in the role as clinical manager for 3 years. She is supported by a Clinical Manager (RN) who was in the role as unit coordinator previously. They both have many years’ experience in aged care. There are job descriptions for both positions that include responsibilities and accountabilities.

Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Bupa Te Whanau provides hospital - medical, geriatric, and rest home level care for up to 64 residents. There were 17 of 18 rest home residents, 37 of 46 hospital residents. The service has 10 rest home rooms approved as swing beds. There are three YPD residents, two under ACC and one palliative care under the medical component of their certificate.

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall.

In 2009, Bupa introduced a person centred care focus which includes six pillars. This has been embedded in service delivery at Te Whanau.

There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Te Whanau has set specific quality goals for 2013 including (but not limited to); a) decrease falls by 2%, b) reduce medication incidents, c)Improve staff completion of Personal Best and Career force core competencies and d) Refurbish the hairdressers space to improve the residents experience.

Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.

There is an overall Bupa business plan and risk management plan.

**Finding Statement**

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Te Whanau is part of the central Bupa region which includes 10 facilities. The managers in the region meet four monthly, senior managers mentor and provide guidance to new managers. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Te Whanau and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Te Whanau annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Te Whanau has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans were rolled out in end 2011. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. The organisation has commenced a Clinical Governance group. The committee is to continue meeting two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Te Whanau management team interviewed described some of their focused improvements that link to organisational goals including; they have implemented person centred care plans, and an efficient system to ensure that care plans are completed within the six month time frame. They have a part time training co-ordinator whom supports staff completing career force qualifications and foundation skill orientation, as well as PDRP for qualified nurses.

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

During a temporary absence, the clinical manager covers the manager’s role. The service is supported by the Bupa Operations Manager. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to people who use the service including residents that require hospital (medical), and rest home level care. The service consults with the Bupa dementia leadership group, gerontology nurse specialists, physiotherapist, dietitian, hospice, and mental health for older people.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** CI

Te Whanau has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team.

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. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team.

Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule.

Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the two monthly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home, and hospital and staff incidents/accidents; b) The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints; c) There is a two-three monthly IC committee at Te Whanau. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. d) Health and safety committee meets three monthly and is also an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation. e) The regional restraint approval group meets six monthly and Te Whanau restraint group meets three monthly. These meetings include a comprehensive review of restraint/enabler use. Restraint internal audit is completed annually.

Te Whanau is commended for the implementation of the quality and risk management process. Monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Te Whanau via graphs and benchmarking reports.

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the Operations Managers region is also provided for the Ops Mgr which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Ops Mgrs mthly summaries).

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Te Whanau and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

D19.3:There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2012 with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury (these have continued over into 2013). On-going review of these objectives for Te Whanau is seen in H&S meeting minutes.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapy team, landing strips by beds and sensor mats. There is a falls focus committee that meets two monthly and reviews repeat fallers and other fall related incidents and management.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

There is a comprehensive quality and risk management process in place. The service monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, Code of rights, weight management, H&S, accident reporting documentation, care planning, Infection control.

Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.

Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee e.g. quality, staff, and an action plan is identified. These were comprehensively addressed in meeting minutes sited.

There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Te Whanau is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified.

The service is active in analysing data collected. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Te Whanau is currently benchmarked in two of these areas- hospital and rest home. Quality indicators are provided to the benchmarking groups. Feedback is provided to Te Whanau via graphs and benchmarking results are discussed. CAR action plans were completed where benchmarking was above i.e. Skin tears above KPI in March 13. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the GM.

**Finding Statement**

There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Te Whanau is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of meetings and discussion with the management team, there continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established on a regular basis where Te Whanau is above the benchmark. i.e.: Jan 2013 - falls were high as a result a CAR was established which included an analysis of falls to identify trends/common themes, also a separate analysis for one resident that included initiating corrective actions for one resident that had nine falls (six being in the pm shift). Cognitive issues identifies as a cause of falls, tracking of frequent fallers and evaluation by the falls focus group. While falls continue to remain high in the hospital, the falls focus group and service continue to provide training to staff and residents and identify trends. Te Whanau has taken on board the Bupa drive for reduction in the use of anti-psychotics with their residents and on-going evaluation of effectiveness of anti-psychotics for those prescribed. Other improvements noted include (but not limited to); Falls prevention - they have identified falls prevention champions that are working toward educating other staff and residents, vitamin D programme to prevent fractures sustained during falls. This is to support their goal to reduce falls. Liverpool Care Pathway –this was rolled out the end of 2010 and has improved care at the end of life for our residents.

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

The service plans and operational structures combine to provide a comprehensive quality development and risk management system. Reports are provided to the quality meeting by key staff including; health and safety rep, infection control rep, kitchen, education, laundry, unit reports and restraint.

Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these.

Benchmarking reports are generated throughout the year to review performance over a 12 month period .

Quality action forms are utilised at Te Whanau to document actions that have improved or enhanced a current process or system or actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, for example, quality meeting, and through newsletters.

The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits as required and completes a report to the general manager, care homes.

**Finding Statement**

The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12 month period . Quality action forms are utilised at Te Whanau and document actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, e.g. quality meeting, resident and staff meeting. Te Whanau has two monthly quality and risk management meetings and includes progress to meeting their annual quality goals.

The quality goals identified at Te Whanau for 2012 include documented quarterly progress and evaluation. Progress is forwarded to the quality management coordinator for Bupa. The Facility Manager provides a documented weekly report to Bupa Operations Manager. The Operations Manager visits monthly and completes a report to the GM. The service completed regular progress reporting and implemented on-going corrective action plans to meet their 2012 goals; In 2012 Te Whanau set three Quality goals, one was in line with the Bupa Bfit programme which has been carried over as a goal for 2013 under Health & Safety; the second was to reduce restraint usage in their facility, and the third to review and improve our activity programme. The service described a number of activities completed during the year for their BFit Programme; including (but not limited to)f, “Biggest Loser” Challenge, this was run by staff and several staff members made significant lifestyles changes and lost weight. They managed to achieve their goal and reduce restraint usage by more than 50% (link 2.2.5). The service identified other improvements implemented from quality initiatives including; changing their drug charts moving to pharmacy generated so that the charts are clearly able to be read and consistent; quarterly Te Whanau newsletter for residents and family provided. Also they have secured an independent person to facilitate Residents/family & friends meetings, starting July 2013. The management team stated that they have strengthened palliative care with staff completing fundamentals of Palliative, a supportive relationship with Arohanui Hospice and the Palliative Resource network group established.

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** CI

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The competed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Bupa have also introduced a dedicated email address to send CAT ones to. Manned by more than one specific person – that was described as an improvement within Bupa Q+R team. A monthly Cat One summary is also sent out to care homes.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

Incident forms reviewed for June 13 identified that all 19 incident forms demonstrated clinical follow up by a registered nurse and monitoring (such as neurological observations) having been undertaken when indicated.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. A recent sudden/unexplained death was reported to required authorities. The service also undertook a thorough review of the resident notes leading up to the death in order to identify any areas for improvement in the delivery of care to the resident and have shared 'learnings around assessment and reporting with staff' as a result.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and qualified staff meeting reflect a discussion of benchmarking results.

Quality Indicators - Analysis and corrective action plan policy (284) includes and objective ' corrective actions will be identified and implemented in response to increases or adverse trends in monthly resident incidents and infection rates.

**Finding Statement**

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and qualified staff meeting reflect a discussion of benchmarking results. The incident/infection analysis tool and quality indicator corrective action plan is well utilised at Te Whanau to assist with analysis and plan improvements to service delivery. There is a number that have been implemented to date across 2013 when benchmarking results are above the normal. For eg: bruising was up in March in the hospital, a CAP was completed which resulted in an analysis of the incidents to identify trends. This was shared with staff at hand-over, tool box talks provided that included manual handling and how to prevent. Corrective actions evaluated identified that all clients with bruising in March now use leg protectors and have been adjusted to their care plans. Bruises reduced April, May.

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven files reviewed files (clinical manager, two registered nurses, three caregivers, and cook) and all had up to date performance appraisals. All staff files included a personal file checklist.

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, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, RN four weeks), during this period they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (six caregivers, one registered nurse) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the clinical manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (These align with Bupa policy and procedures).

Twenty-five caregivers (66%) have completed national caregiver training pathways (e. foundation skills/ national CSOP /ACE/residential LCP etc.). Six are currently working on these. Three caregivers are verifiers for careerforce. Nine have palliative care certificates; two are members of Palliative Resource Network Group.

There are seven registered nurses. All RNs attended external education e.g. DHB/ other providers. Three registered nurses hold additional roles of Infection Control officer, Restraint Coordinator and LCP Resource Nurse. Six have palliative care training; two are members of Palliative Resource Network Group. One registered nurse is a careerforce assessor, two are preceptors.

There is an annual education schedule that is being implemented. In addition opportunistic education is provided by way of tool box talks. There is an RN training day provided through Bupa that covers clinical aspects of care - eg. Wound management. There is evidence on RN staff files of attendance at the RN training day/s and external training.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At Te Whanau, the clinical manager has completed her portfolio on the Bupa Nursing Council approved PDRP and the other RNs are being supported to do this.

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management , CPR, and T34 syringe driver.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. 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.

There is a Facility Manager (RN) Mon - Fri and a Clinical Manager (RN) Mon - Fri and 24 registered nurse cover.

Interviews with five relatives and 11 residents all confirmed that staffing numbers were adequate. Management and caregivers interviewed stated that the manager was currently employing more caregivers to cover casual shifts.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The resident 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. An initial support plan is also developed in this time.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure cabinet or secure storage for unused files.

Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing.

Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. There is also an allied health services assessment form with care requirements.

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

**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.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Bupa Te Whanau has a well-developed assessment process and resident’s needs are assessed prior to entry. Information gathered on admission is retained in resident’s records. Residents and/or family/whanau are provided with an information pack on entry to the service. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

Residents and family members confirm/sign off that an assessment process is completed on admission and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.

Information gathered at admission is retained in resident’s records. Six rest home and five hospital residents interviewed stated they were well informed upon admission. Five relatives interviewed stated that they were able to discuss the admission process with the manager or clinical manager prior to admission and were well informed. One relative stated that they had corresponded with the manager by email and telephone when they needed some questions answered.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARHSS D4.2

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an admission information policy that describes the declined entry to services process. The referral agency and potential resident and/or family member is informed of the reason for decline.

**Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an implemented admission role of caregiver policy, an admission role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.

D16.2, 3, 4: The eight files reviewed (five hospital and three rest home) identified that an assessment was completed within 24 hours. All eight files reviewed identify that the long term care plan (lifestyle plan) is completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Six of eight lifestyle plans evidenced evaluations completed at least six monthly. One hospital and one rest home resident were not long enough in the service to undergo six monthly review.

There is sufficient information gained through the initial support plan, specific assessments, the short-term care plan, and the lifestyle plans in all files reviewed to guide staff in the safe delivery of care to residents.

Activity assessments and the activities sections care plans have been completed by the activities coordinator. All eight files have at least an initial physiotherapy assessment completed with on-going assessments as necessary. Residents interviewed five hospital and six rest home stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family/whanau contact records which were completed and up to date in all resident files sampled.

D16.5e: Eight resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and were to be reviewed three monthly. More frequent medical review was evidenced occurring in files of residents with acute conditions and residents receiving palliative care.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale ), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. A managers report is completed by the registered nurse on duty on each shift. All resident files reviewed identified integration of allied health and a team approach. The GP interviewed described effective communication processes between the nursing staff and doctors and commented the service provided a proactive approach to care and treatment.

Tracer Methodology:

Rest home resident:

*XXXXXX This information has been deleted as it is specific to the health care of a resident*.

Hospital resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident*.

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Assessment booklet includes the following assessment tools; falls, Braden, skin, mini nutritional, continence, pain, dependency and activities. Risk assessment tools and monitoring forms are reviewed at least six monthly and are used to assess the level of risk and required support for residents.

Personal needs information obtained on admission interview includes (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information.

Needs outcomes and goals of residents are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by the registered nurses.

Eight resident files sampled contain assessments including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, skin assessment, MNA, incontinence assessment, behaviour assessment, and wound assessment (where appropriate). Assessments and support plans include input from allied health. The assessment booklet includes input from team members.

Notes by GP and allied health professionals are evident in residents files, significant events, communication with families and notes as required by registered nurses. Five families interviewed are complimentary of the care provided.

**Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The sample of files reviewed included; five hospital residents and three rest home residents.

Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and input from allied health. Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Lifestyle plans include clear direction for staff and are reflected in the progress notes. All eight lifestyle plans reviewed provide evidence of individualised support and intervention required.

D16.3f: Eleven residents (six rest home and five hospital) and five family members interviewed confirm care delivery and support by staff is consistent with their expectations. All eight resident files reviewed identified that family were involved. All needs identified in the assessment process were included in the lifestyle plans.

D16.3k: Short term care plans are in use for changes in health status.

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents' lifestyle care plans are completed by the registered nurses. Care delivery is recorded by caregivers on each shift and follow up by registered nurses is documented for any changes in residents condition reported (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The six caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence and wound care products were sighted stored in each wing.

D18.3 and 4 Dressing supplies are available and a treatment rooms are well stocked for use. Wound assessment and wound management plans are in place for 11 residents (11 wounds). Wounds include: one grade II and two grade I pressure areas, four skin tears, one surgical wound, two SCC and one chronic malignant wound. Grade II pressure area wound evidences input from an external wound care specialist. All wound pressure areas have pressure relieving devices documented within their wound management plan, pressure relief monitoring charts/turning charts and have been referred to dieticians for nutritional assessments. An incident/ accident form was evidenced completed for a grade I pressure area. Two residents were admitted to the service with pressure areas. The registered nurse and clinical manager (CM) interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Three registered nurses have had specialised wound management training in April 2013. Wound management was discussed at a tool box talk which took place in February 2013 with 12 staff attending.

Continence products are available and resident files include a 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. Continence management in-services has occurred. The facility has registered nurse cover 24/7 and has a comprehensive ‘in service’ education programme and toolbox talks on areas identified as special interest.

A physiotherapist is contracted four hours per fortnight.

During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an activity co-ordinator who works 08.30-16.30 hrs. Monday-Friday. The activities co-ordinator attends Horrowhenua District Diversional Therapists Network meetings which are held monthly. The activities co-ordinator provides activities in the lounge areas, gardens and also provides one on one input in residents rooms when required.

On the day of audit residents in the facility were observed being actively involved with a variety of activities. The programme is developed monthly and a weekly planner is displayed in large print. Residents also receive a personal copy. There are monthly themes. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.

Information from the social history taken is fed into the lifestyle plan and this is reviewed six monthly as part of the lifestyle care plan review/evaluation. A record is kept of individual resident’s activities and progress notes completed. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in the rest home and hospital. Participation in all activities is voluntary. The programme is comprehensive and designed for the differing levels of cognitive and physical functions of residents and caters for the individual needs including diversional plans for challenging behaviours.

There are weekly church services. Anglican services are held monthly. There is a combined Presbyterian/Methodist service held monthly. The Catholic church visit their parishioners weekly and provide Holy Communion/Eucharistic services. There is one resident of Jewish faith and the Rabbi visits often.

There is an exercise programme to promote balance, reduce falls and maintain or improve residents' range of movement.

The programme includes networking within the community with social clubs. There are outings to the RSA, Salvation Army and Oasis club. Residents are invited to Summerset Village once a month to join in activities with residents at that facility. Some of the residents at Te Whanau used to live in Summerset Village and the monthly outings there allow them to meet up with old friends. The facility also participates in joint activities/outings with its sister Bupa site Garden View. There are entertainers booked to come and entertain residents monthly.

Recently a pumpkin soup recipe competition was held as residents had been growing pumpkins in the raised garden beds and wanted some recipes so that they could sample the vegetables they had grown.

Eight residents interviewed stated they were very happy with the activities programme and were given choice regarding participation.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. Residents report they are very satisfied with the activity programme offered to them by the facility and that they have easy access to local churches, library, social clubs, church services held within the facility and participate in activities of choice.

To meet the 2012 quality activity goal the following was completed; a) they evaluated their current activity programme using a client questionnaire to gather information, b) Feedback from client questionnaire was shared with activity officer and quality committee. Activities identified by clients that they enjoyed were kept in the programme and deficits such as smaller group activity, arts/crafts were added, c) Resident satisfaction survey results were 96% satisfaction and 87% satisfaction over the past two years.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is at least a one- three monthly review by the medical practitioner. D16.4a Lifestyle plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in six of eight care plans sampled (two residents are new to the service). There is at least a three monthly medication review by the medical practitioner.

There are short term care plans (STCPs) to focus on acute and short-term issues. Changes to the long term lifestyle care plan are made as required and at the six monthly review if required. Examples of STCP's use included; infections, wounds, challenging behaviours, and unexplained weight loss.

ARC D16.3c: All initial care plans were evidenced to be evaluated by a registered nurse within three weeks of admission.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, mental health services, hospital specialists, palliative care nurse specialist and wound care nurses.

D16.4c: The service provided examples of a recent referral to the NASC team for reassessment for a higher level of care for one rest home resident who has increased medical/care needs. The clinical manager waiting to be notified of assessment date.

D 20.1; Discussions with registered nurses identified that the service has access to wound care nurse specialists, incontinence specialists, palliative care nurses, psychogeriatrician, mental health team, and dietitians.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of details is kept on the resident’s file. This was sighted in one resident files (rest home), where the resident had been transferred to hospital as an emergency admission. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

**Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

Medication policies align with accepted guidelines. Medications are stored in locked trolleys in the treatment room in the hospital and a locked storage area in the rest home. Controlled drugs are stored in a locked cupboard in the locked treatment room in the hospital and two people (one being an RN), must sign controlled drugs out. There is an improvement required around the documenting of controlled medications in the controlled drug register, this was addressed by the service on day of audit. The service uses two weekly robotic packs. Medication charts have photo ID’s. The facility has changed to using pharmacy generated medication charts in June 2013. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.

There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheet. The medication folders include a list of specimen signatures and competencies.

All 'medication competent' staff are responsible for medication administration in all areas. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medication management training was held in May 2013.

There are currently two hospital and one rest home resident self-administering inhaler and sub lingual medications. A registered nurse assessment to self-administer inhalers and sublingual spray were evidenced completed in medication folders.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies, e) duplicate name.

D16.5.e.i.2; Fourteen of sixteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Two medication chart reviewed were for recent admissions. Medication audits are completed six monthly.

**Criterion 1.3.12.1 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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Controlled medications which are not hospital bulk stock were observed to be collectively documented in the controlled drug register. This change of practice was introduced on the advice of the pharmacist.

**Finding Statement**

Controlled medications were evidenced documented in the controlled drugs register. However, controlled drugs prescribed and packaged for individual residents were not documented on individual pages. All controlled medications of the same name and strength were evidenced recorded collectively under the drug of same name and strength of medication. Weekly checks of stock balance were evidenced completed by the clinical manager and a registered nurse.

**Corrective Action Required:**

Ensure that controlled medications prescribed and dispensed by pharmacy for individual residents are documented on an individual page in controlled drug register with residents name and strength of medication immediately. This was addressed on the day of audit and the service provided evidence that all individual residents had individual pages in the Controlled Drug register

**Timeframe:**

1 month.

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'.

The national menus have been audited and approved by an external dietitian.

The service employs three cooks. There are kitchen hands and veg prep assistants who are employed to work in the kitchen. D19.2 All of the kitchen team at Bupa Te Whanau have completed food safety certificates. The cooks have completed NZQA 167 and 168 qualifications. The service has a large workable kitchen that is well equipped. There is a preparation area and receiving area. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. There is a resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. A food service audit conducted in May 2013 attained a score of 100%.

There is a nutrition - assessment and management policy (347) and a weight management policy (079). An audit of resident weights was completed in February 2013 which attained a score of 98%.

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the lifestyle plan review or sooner if required. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets, high protein, vegetarian. There is one Jewish resident who has cultural needs related to food which are respected and catered for.

There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety.

Daily temperature checks of chiller, freezers, bain marie and dishwasher are maintained.

Residents interviewed (six rest home and five hospital) reported satisfaction with the food service and described being offered an alternative choice if they did not like what was on the menu.

Bupa Care Homes introduced in 2010 a comprehensive food services programme that specifically targeted all areas of the food service as a quality improvement initiative throughout the business. This was in response to further improving on client satisfaction results with the service as identified through resident/relative satisfaction surveys. Achievements of the programme which continues in 2012 include the introduction of a Steering group, monthly teleconferences with the chefs/cooks employed in each home, development of Bupa's own Recipes and Library of these and the review and update of all kitchen policies and procedures. Other activities included the development of "assisted eating posters" which a "Master chef" DVD with Annabelle White, a dementia specific focus included emphasis on use of coloured crockery and suitable tasty finger foods and a streamline national food contract supply for meat, groceries and vegetables. The programme also developed food safety training power points to augment the internal core education programme within care homes. A senior chef within the business provides support and mentorship to the cooks in each of the homes and following the pilot of a training programme for staff, Bupa kitchen staff complete unit standard 167 Food safety training. “Showing we care on a plate” was the title/catch phrase for the programme.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**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.

ARC D19.3c.v; ARHSS D19.3c.v

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Chemical/substance safety policy (048). There are policies on the following:- waste disposal policy. - medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics. Procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff and an education session was conducted in January 2013 on chemical safety.

All chemicals are clearly labelled with manufacturers labels. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols.

Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. A waste/chemical kitchen audit was conducted in March 2013 attaining a score of 100%.

**Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a maintenance person who works a total of 24 hours per week and on call. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 25-Aug-13. Electrical equipment is checked annually. Maintenance person interviewed reports that medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. (Records were sighted). The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen/dining areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

The external areas are well maintained and gardens are attractive. There is garden furniture and plenty of shade. There is wheelchair access to all areas. The garden is secure and there is shade.

Caregivers (six), one RN and one CM interviewed reported that there are good resources available including; standing and full sling hoists, shower chairs, pressure relieving mattresses, transfer belts, slippery sams, pressure relieving cushions, special pressure reliving chairs and specialist crockery and cutlery. Staff reported that if there is a need for equipment identified it is acted upon and obtained by the manager. There is a transportation policy and driver’s licences are checked. The facility has a van available for transportation of residents which they share with Bupa Garden View. Those transporting residents hold a current license and first aid certificate. A van safety audit was completed in May 2013 attaining 93%. Corrective actions identified were signed off when completed.

There is a Bupa Product Evaluation Committee. This group was established two years ago with the key aim of ensuring the clinical equipment the company purchases remains fit for purpose and continues to meet the needs of staff and residents.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are en suites in the hospital wing, there are ten toilets and eight shower/toilets throughout the facility which are adequate for the service needs along with visitor & staff toilets. Communal toilets and bathrooms have appropriate signage and shower curtains installed. Fixtures and fittings are well maintained and appropriate. Hot water is monitored fortnightly and kept at an appropriate 43 to 45 degrees.

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The rooms are spacious it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Six caregivers report that rooms have sufficient space to allow cares to take place

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are two lounge dining rooms, two quiet lounges and a large dining room. Residents and assistants are able to move freely. There are several lounges that residents can choose from. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Eleven residents interviewed report they can move around the facility and staff assist them if required.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed six monthly. An environmental hygiene - cleaning audit was last completed in march 2013 attaining 96%. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. There is a keypad lock system on the laundry. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer’s labels. There is sluice rooms for the disposal of soiled water or waste. Resident’s satisfaction survey completed in February 2013 reports 94% satisfaction with the laundry service. Corrective actions identified have been addressed. Interviews with families/residents identified consistent feedback regarding the excellent and consistent cleanliness of the facility. This was also identified during a tour of the facility by the audit team.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Appropriate training, information, and equipment for responding to emergencies is provided. Fire evacuations are held six monthly. A fire drill and fire safety training was last held on Feb 13. There is an approved evacuation scheme dated 19th October 2005.

There is a staff member each shift with a current first aid certificate. First aid/CPR training was completed by 11 staff April 13. Emergency procedures training occurred Sept 12 (18 attended).

There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents’ details. There is an approved evacuation plan dated 13 June 2006.

The facility is well prepared for civil emergencies and has emergency lighting and BBQ’s. A store of emergency water is kept. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits.

Hoists have battery back and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept.

There is a store cupboard of supplies necessary to manage a pandemic.

The call bell system is available in all areas and indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were overall answered in a timely manner.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The facility has gas fired central heating with two new boilers having recently been installed. Temperature can be controlled in each area/room; rooms are well ventilated and light. The service has also had all new LED lighting installed earlier in 2013 as part of upgrade and falls prevention strategy.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Restraint policy (251) states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated".

There is a regional restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has four residents on the register with an enabler in the form of a bedrails and wheelchair lap belts. The file reviewed of one resident identified as having an enabler in the form of a wheelchair lap belt included a comprehensive enabler assessment that covered alternatives and least restrictive options.

The service currently has two residents (bedrails) in the hospital assessed as restraint. A register for each restraint is also completed that includes a monthly evaluation.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**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.

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Only staff who have completed a competency assessment are permitted to apply restraints. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. Interviews with the restraint coordinator (clinical manager) and review of signed job description identified understanding of the role.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool and enabler assessment tool available and completed for the residents requiring bedrails for safety. The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. One restraint file was reviewed of a resident with a bedrail. A restraint assessment form was completed, the assessment considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly (written evaluation sighted).

**Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:**

(a) Any risks related to the use of restraint;

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is the clinical manager and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed at least three monthly within the facility restraint meeting and also as part of three monthly restraint register reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. Advised by the restraint coordinator that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

The resident file reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed of the hospital resident with restraint identified observations and monitoring. Restraint use is reviewed through the three monthly assessment evaluation, three monthly restraint meetings and six monthly multidisciplinary meeting and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred three monthly as part of the on-going reassessment for the residents on the restraint register, and as part of care plan review. Families are included as part of this review. A review of one file identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed on a formal basis three monthly through restraint register review and by the facility approval team. Evaluation timeframes are determined by risk levels.

**Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:**

(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;

(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;

(f) The duration of the restraint episode and whether this was for the least amount of time required;

(g) The impact the restraint had on the consumer;

(h) Whether appropriate advocacy/support was provided or facilitated;

(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

(j) Whether the service's policies and procedures were followed;

(k) Any suggested changes or additions required to the restraint education for service providers.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** CI

Individuals approved restraint is reviewed at least three monthly through the restraint meeting and as part of six multi dip review with whanau involvement.

Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at Regional Restraint Approval groups. The organisation and facility are proactive in minimising restraint and the service is commended for their on-going review process.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Individual approved restraint are reviewed three monthly through the register, three monthly through the restraint meeting and as part of six multi dip review with whanau involvement.

Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at Regional Restraint Approval groups.

**Finding Statement**

Individuals approved restraint is reviewed at least three monthly through the restraint meeting and as part of six multi dip review with whanau involvement. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at Regional Restraint Approval groups. The organisation and facility are proactive in minimising restraint. Bupa analysis for 2012 has been shared with the restraint coordinators across the organisation. The organisation started the year off with a rate of 2.9 (269 people being restrained) and finished on 2.7 (254 people being restrained). No-one has been restrained in any rest home unit since April 2011. Hospital rate of restraint reduced over 2012 from 5.4 down to 4.8. In dementia, three care homes using restraint at some point – however by December, back to nil again. There have been mixed results in psycho-geriatric where the rate actually increased over the year from 5.8 to 6.0. There are now 12 care homes that have maintained a restraint free environment during the year (26%) restraint free. In January 2009 they had 502 residents (rate of 5.7) restrained across all care homes and types, at the end of December 2012 they had 254 residents (rate of 2.7) restrained. Over four years this is a reduction of 49% in raw numbers. Te Whanau restraint usage has come down since the last audit . With a strong drive to implement other measures and use restraint as a last resort they have gone from 85% bedrails and 15% lap belts in hospital 2011 to 45% in 2012 and 3% in 2013. They have worked hard to maintain this status through three monthly meetings, regular falls risk assessments of residents, implementation of the falls focus committee, assessments by physiotherapists, regular training and staff competencies. A facility restraint report has been completed annually that analysed restraint-use across the year.

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**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.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The infection control committee includes a cross section of staff all areas of the service.

The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, Community Lab, the infection control and public health departments at the local DHB. There are two monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff.

Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

A scabies outbreak May 2012 (involving two residents) included a special report, special meeting including consulting GP and pharmacist, notified all family/consents obtained, toolbox talks provided to staff, info sheets/notices and all staff/residents treated.

**Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the facility manager, clinical manager, and other staff. The facility also has access to an infection control nurse, public health, community lab, GP's and expertise within the organisation.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.

There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.

Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.

External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator, the infection control committee and expertise from the governing body.

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control (IC) coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has attended Bug control training. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, and Bug Control for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was held on Feb 13, toolbox talk Feb 13, and UTIs June 13. All training is mandated by Bupa and evaluated by staff who attend. Records of the evaluations were sighted.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza and gastro bugs.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** CI

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager’s report on quality indicators.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The service is commended for their continued improvement approach around follow up actions of infections and clinical indicators.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Infection control data is collated monthly and reported to the Quality and IC meeting. The meetings include the monthly IC report. Infections are documented on the Infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC Programme is linked with the Quality Management Programme. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. There is a number of internal audits completed including (but not limited to) standard precautions (June 99%), Food Service (May 100%), and Environmental Cleanliness (Mar 96%)

**Finding Statement**

The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC stats are discussed at qualified staff and IC meetings and corrective actions are implemented when infections increase. Incident/infection - analysis tool is utilised to assist with identifying trends. In May 13 an increase in respiratory tract infections and UTIs (six hosp/two rest home) resulted in two QIPs being developed. QIPs included analysis of current management plans, review of effectiveness and on-going observations as per STCPs. Toolbox talks provided to staff included (but not limited to); UTIs in June 13. Corrective actions implemented resulted in decrease in UTIs and RTIs in June 13. Infection stats, trends and education are regularly provided via noticeboards and meetings to staff, residents and relatives.

**Corrective Action Required:**

**Timeframe:**