

Bupa Care Services NZ Limited - Riverside Care Home and Hospital

CURRENT STATUS: 19-Aug-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

Bupa Riverside is part of the Bupa Group. Riverside provides care at two service levels (hospital and rest home level care). On the day of the audit there were 17 residents receiving hospital level care and 16 receiving rest home level care.

The facility manager has been at the service since October 2012. She has had many years' experience in the aged care sector and is a registered nurse. She has previously managed the facility under different ownership. The facility manager is supported by the regional manager (a registered nurse). She is also supported by an experienced clinical manager (registered nurse). Families and residents spoke highly of the care provided at Riverside. There has been significant refurbishment undertaken since Bupa purchased the facility and this continues.

This audit has identified improvements required around care planning, wound management, medication management and continuing planned refurbishments.

AUDIT SUMMARY AS AT 19-AUG-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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights	Day of Audit 19-Aug-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.		Standards applicable to this service fully attained

Organisational Management	Day of Audit 19-Aug-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.		Standards applicable to this service fully attained

Continuum of Service Delivery	Day of Audit 19-Aug-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 medium or high risk and/or unattained and of low risk

Safe and Appropriate Environment	Day of Audit 19-Aug-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.		Some standards applicable to this service partially attained and of low risk

Restraint Minimisation and Safe Practice	Day of Audit 19-Aug-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained

Infection Prevention and Control	Day of Audit 19-Aug-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.		Standards applicable to this service fully attained

AUDIT RESULTS AS AT 19-AUG-13

Consumer Rights

Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information is made available to family on the services provided and on the Code of rights for residents at the time of admission. Consumer rights during service delivery are respectful of residents rights, facilitates choice, minimises harm and acknowledges cultural and individual values and beliefs. Information on the nationwide advocacy service is available in the entranceway to the facility. There is an improvement required around including this information in the information packs given to clients. The service has policy to support rights such as privacy, abuse/neglect, culture, complaints, advocacy and informed consent. Service planning accommodates individual choices of residents. Policies for culturally safe services are in place and identify the importance of whanau for Maori. Interviews confirmed the service promotes residents independence in activities of daily living. Residents access services and resources within the community as appropriate and/or requested.

Organisational Management

There are quality and risk management systems noting that these are being implemented following the purchase of the service in October 2012. Data that is collected is compared with other similar facilities and is used to highlight where opportunities for improvement exist. There are processes in place for reporting quality and risk performance. 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.

The service collects incident and accident data to provide a clear account of the incident, what actions were taken in response, who and when people were informed, any detail that will assist in determining how the incident occurred and what actions were taken/are required to prevent recurrence.

The service has comprehensive human resources procedures for staff recruitment. The orientation programme provides new staff with relevant information for safe work practice and this includes a buddy system to ensure that staff are orientated in a hands on way. There is an annual education schedule that is being implemented and staff state that this provides sound guidelines for practice. Staffing levels safely meet the needs of the residents at both a hospital and rest home level.

Continuum of Service Delivery

The service has an admission policy and process. 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.

A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around care planning and wound management.

Medicines are managed and policies reflect legislative requirements. 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 weekly controlled drug checks and signing sheet documentation.

The activities programme is facilitated by an activities coordinator. The activities programme provides varied options and activities are enjoyed by the residents. Each resident has a comprehensive individualised plan. Community activities are encouraged, van outings are arranged on a regular basis.

All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietician.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is evidence of compliance with appropriate legislative requirements are met. Protective equipment and clothing is provided and used by staff. The service documentation provides evidence there are appropriate systems in place to ensure the residents physical environment and facilities are fit for their purpose. There is a current building warrant of fitness. The service has undergone significant refurbishment since the previous audit and

this process continues. There is improvement required around continuing refurbishments. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. Documented systems are in place for essential, emergency and security services. Staff interviews detailed current training in relevant areas. There are alternative energy and utility sources are maintained and security systems are in place. A staff with a current first aid certificate is always on duty. The home is warm and bedrooms personalised. Maintenance is routinely carried out by the service.

Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what is a restraint and what is an enabler. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has three residents on the register with an enabler in the form of a bedrails with one resident also using a lap belt. There is a restraint register with three residents using a bedrail identified as a restraint. The restraint coordinator reviews all residents identified as requiring restraint three monthly and there is a full review in line with the care plan six monthly including discussion at the multidisciplinary review. Monitoring of the restraint is at least two hourly as sighted in the care plan reviewed and this is documented while the restraint is in place.

The care plans reviewed focus on promotion of quality of life and minimise the need for restrictive practises through the management of any needs identified. The operations manager and facility manager along with the restraint coordinator describe a focus in the coming months in reducing the use of restraint.

Infection Prevention and Control

Bupa Riverside has an infection control programme that complies with current best practice. There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the registered nurse meetings and outcomes are reported to staff through nursing and staff meetings. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

Riverside Care Home & Hospital

Bupa Care Services NZ Limited

Certification audit - Audit Report

Audit Date: 19-Aug-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RcompN, PGDipHSM, Auditor certificate	12.00	6.00	19-Aug-13 to 20-Aug-13
Auditor 1	XXXXXXXX	MBA MN B Ed Adv Dip Child and Family Dip Tchg RGON Lead Auditor	12.00	6.00	19-Aug-13 to 20-Aug-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			2.00	

Total Audit Hours on site	24.00	Total Audit Hours off site <i>(system generated)</i>	14.00	Total Audit Hours	38.00
Staff Records Reviewed	7 of 35	Client Records Reviewed <i>(numeric)</i>	6 of 33	Number of Client Records Reviewed using Tracer Methodology	2 of 6
Staff Interviewed	11 of 35	Management Interviewed <i>(numeric)</i>	2 of 2	Relatives Interviewed <i>(numeric)</i>	5
Consumers Interviewed	6 of 33	Number of Medication Records Reviewed	12 of 33	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

I, (full name of agent or employee of the company) XXXXXXXX (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 of Health 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 day of September 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*):

Executive Summary of Audit

General Overview

Bupa Riverside is part of the Bupa Group. Riverside provides care at two service levels (hospital and rest home level care). On the day of the audit there were 17 residents receiving hospital level care and 16 receiving rest home level care.

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This audit has identified improvements required around care planning, wound management, medication management and continuing planned refurbishments.

1.1 Consumer Rights

Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information is made available to family on the services provided and on the Code of rights for residents at the time of admission. Consumer rights during service delivery are respectful of residents rights, facilitates choice, minimises harm and acknowledges cultural and individual values and beliefs. Information on the nationwide advocacy service is available in the entranceway to the facility. There is an improvement required around including this information in the information packs given to clients. The service has policy to support rights such as privacy, abuse/neglect, culture, complaints, advocacy and informed consent. Service planning accommodates individual choices of residents. Policies for culturally safe services are in place and identify the importance of whanau for Maori. Interviews confirmed the service promotes residents independence in activities of daily living. Residents access services and resources within the community as appropriate and/or requested.

1.2 Organisational Management

There are quality and risk management systems noting that these are being implemented following the purchase of the service in October 2012. Data that is collected is compared with other similar facilities and is used to highlight where opportunities for improvement exist. There are processes in place for reporting quality and risk performance. 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.

The service collects incident and accident data to provide a clear account of the incident, what actions were taken in response, who and when people were informed, any detail that will assist in determining how the incident occurred and what actions were taken/are required to prevent recurrence.

The service has comprehensive human resources procedures for staff recruitment. The orientation programme provides new staff with relevant information for safe work practice and this includes a buddy system to ensure that staff are orientated in a hands on way. There is an annual education schedule that is being implemented and staff state that this provides sound guidelines for practice. Staffing levels safely meet the needs of the residents at both a hospital and rest home level.

1.3 Continuum of Service Delivery

The service has an admission policy and process. 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.

A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the GP and allied health professionals. There are improvements required around care planning and wound management.

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All food is cooked on site by the cook. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietician.

1.4 Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is evidence of compliance with appropriate legislative requirements are met. Protective equipment and clothing is provided and used by staff. The service documentation provides evidence there are appropriate systems in place to ensure the residents physical environment and facilities are fit for their purpose. There is a current building warrant of fitness. The service has undergone significant refurbishment since the previous audit and this process continues. There is improvement required around continuing refurbishments. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. Documented systems are in place for essential, emergency and security services. Staff interviews detailed current training in relevant areas. There are alternative energy and utility sources are maintained and security systems are in place. A staff with a current first aid certificate is always on duty. The home is warm and bedrooms personalised. Maintenance is routinely carried out by the service.

2 Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what is a restraint and what is an enabler. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has three residents on the register with an enabler in the form of a bedrails with one resident also using a lap belt. There is a restraint register with three residents using a bedrail identified as a restraint. The restraint coordinator reviews all residents identified as requiring

restraint three monthly and there is a full review in line with the care plan six monthly including discussion at the multidisciplinary review. Monitoring of the restraint is at least two hourly as sighted in the care plan reviewed and this is documented while the restraint is in place.

The care plans reviewed focus on promotion of quality of life and minimise the need for restrictive practises through the management of any needs identified. The operations manager and facility manager along with the restraint coordinator describe a focus in the coming months in reducing the use of restraint.

3. Infection Prevention and Control

Bupa Riverside has an infection control programme that complies with current best practice. There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the registered nurse meetings and outcomes are reported to staff through nursing and staff meetings. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

Summary of Attainment

1.1 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 1.1.6	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	FA	0	1	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

Consumer Rights Standards (of 12):	N/A:0	CI:0	FA: 12	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:0	FA:23	PA:0	UA:0	NA: 0			

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	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	FA	0	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	0	0	0	4
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

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 7	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:0	FA:22	PA:0	UA:0	NA: 0		

1.3 Continuum of Service Delivery

		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	PA Moderate	0	1	1	0	0	5
Standard 1.3.6	Service delivery / interventions	PA Low	0	0	1	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 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 9	PA Neg: 0	PA Low: 1	PA Mod: 2	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:18	PA:3	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

		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	PA Low	0	2	1	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

Safe and Appropriate Environment Standards (of 8):	N/A:0	CI:0	FA: 7	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 36):	CI:0	FA:16	PA:1	UA:0	NA: 0		

2 Restraint Minimisation and Safe Practice

		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	FA	0	1	0	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 0	CI:0	FA: 6	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:0	FA:9	PA:0	UA:0	NA: 0		

3 Infection Prevention and Control

		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	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 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 29): CI:0 FA:9 PA:0 UA:0 NA: 0

Total Standards (of 50) N/A: 0 CI: 0 FA: 46 PA Neg: 0 PA Low: 2 PA Mod: 2 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: 0 FA: 97 PA: 4 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:19-Aug-13 End Date: 20-Aug-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.3.5	1.3.5.2	PA Moderate	<p>Finding: One of the six plans reviewed was last updated in November 2012 and the resident has had an increase in falls risk, unintended weight loss and started experiencing pain since this time. These issues are not addressed in the care plan and this is an area requiring improvement.</p> <p>Action: Ensure care plans reflect current needs and are updated when needs change.</p>	3 months
1.3.6	1.3.6.1	PA Low	<p>Finding: Four of the 17 wounds have not been reviewed in the timeframe stated.</p> <p>Action: Ensure all wounds are reviewed within the timeframe stated.</p>	3 months
1.3.12	1.3.12.1	PA Moderate	<p>Finding: (i) Six of 16 medication administration sheets sampled have medication that is prescribed regularly but is not always signed as administered regularly. (ii) Controlled drug checks have not always occurred weekly.</p> <p>Action: (i) Ensure medications are administered as prescribed. (ii) Ensure controlled drug checks occur weekly.</p>	3 months
1.4.2	1.4.2.4	PA	<p>Finding:</p>	6 months

		Low	<p>There are a number of areas of paintwork, ceiling panels, carpet and one broken window that require repair and are included in the planned refurbishment.</p> <p>Action: Ensure all areas of the building requiring repair are included in the planned refurbishment.</p>	
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Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Limited
Type of Audit: Certification audit
Date(s) of Audit Report: Start Date:19-Aug-13 End Date: 20-Aug-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXX

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 Mal 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 including four of four caregivers 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 competency questionnaires. The last training for code of rights was in August 2013 with 10 staff attending.

Interviews with three of three caregivers showed an understanding of the key principles of the code of rights.

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 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 six of six residents including three hospital and three rest home identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Interviews with five of five relatives including three hospital and two rest home confirmed they are informed of the code of rights and the informal 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. The policy includes confidentiality, privacy, collection of Information, storage of Information, and access to health information (disclosure). Communication training was provided in February 2013 (13 attended) and this included principles of privacy.

The personal objects of significance policy outlines the process for the care of personal objects. During the tour of the facility respect for privacy and personal space was demonstrated.

Resident files are held in the locked nurses' office. Interview with caregivers (three) and two registered nurses could explain ways resident privacy is maintained.

There are no double rooms in the facility.

Interviews with six of six residents including three hospital and three rest home residents confirmed that privacy is ensured.

The October 2012 resident satisfaction survey identified that 92% resident's stated privacy was either excellent or good.

Resident information includes Bupa vision and values. Discussions with six of six residents including three hospital and three rest home residents and five of five relatives including three hospital and two rest home 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 (confirmed on interview).

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 that staff are obliging around choice. Care plans reviewed identified specific individual likes and dislikes.

Four of four caregivers 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 2012 resident satisfaction survey, 86% of residents stated excellent or good.

A neglect and abuse policy (201) includes definitions and examples of abuse. Staff could describe definitions. Relatives interviewed (five) said that the care provided is overall very good and staff are very caring. Abuse and neglect training was last delivered in March 2013 (14 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

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 ADHB 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. Bupa Riverside 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 Bupa Riverside 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 no residents that identify as Maori currently however four of four caregivers interviewed confirmed their knowledge of different cultural practices.

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 of five relatives including three hospital and two rest home all identified that values and beliefs were considered. Discussion with six of six residents including three hospital and three rest home all stated that staff took into account their culture and values.

D3.1g The service provides a culturally appropriate service by listening and responding to resident needs and issues.

D4.1c Care plans reviewed included the residents 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. There is policy to guide staff practice: Gift, Gratitude's and Benefits, Delegations of Authority. Qualified nurses meeting (monthly) include any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. Interviews with two registered nurses 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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, psychogeriatric/mental health services. A quality improvement programme is implemented that includes performance monitoring.

A2.2 Services are provided at Bupa Riverside that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. A focus of the service since its purchase in October 2012 has been the emphasis on introducing and implementing 'the Bupa way'.

D1.3 All approved service standards are adhered to.

D17.7c There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

The service has identified key issues post purchase and is working to address these including refurbishment of the rooms.

Five of five relatives including three hospital and two rest home and six of six residents including three hospital and three rest home confirm that there is excellent support provided by staff with improvements noted since Bupa has purchased the service.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>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.</p> <p>The two registered nurses interviewed state that they record contact with family/whanau on the family/whanau contact record (confirmed in six of six files reviewed including three rest home and three hospital). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed (22) identified that family were notified.</p> <p>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 Bupa Riverside with a result of 94%.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 are a number of staff who are able to assist with interpreting for care delivery.</p> <p>A policy on contact with media is also available.</p> <p>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</p> <p>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.</p> <p>D16.4b Five of five relatives including three hospital and two rest home state that they are always informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents</p>	

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) catheterisation, and b) sub cut fluids. Required consent forms and advance directive forms were evident on six resident files reviewed.

Discussions with four caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with two registered nurses 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 six resident files reviewed. The service is working through ensuring all files evidence written discussion with family.

D13.1 There were six admission agreements sighted and these had been signed on the day of admission

D3.1.d Discussion with five family (three from the hospital and two from the rest home) 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Advocacy policy (026) states 'All residents will be informed of their right to an advocate' – information on the availability of advocacy services is held within the Admission Agreement. The Health and Disability Advocacy services brochure will be provided by the facility as part of the Admission Information Pack and will be displayed in the facility'.

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with two registered nurses and four caregivers described how residents are informed about advocacy and support.

Interviews with six of six residents including three hospital and three rest home 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.

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

D3.1h; All relatives interviewed including five of five relatives including three hospital and two rest home state they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit.

There is a family/whanau - participation and contact policy (476). 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 and attending the residents own church service. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with six residents confirm that the activity staff help them assess the community.

D3.1.e Discussion with three caregivers indicate that residents are supported and encouraged to remain involved in the community and external groups. The following personal best examples were provided in regards to accessing the community weekly shopping, groups to the RSA and church functions.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The complaints procedure (065) states 'The facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint management record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to care services via the facility benchmarking spread sheet'.

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. There is a complaints register that is up to date and includes relevant information regarding the complaint. 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 residents and five relatives confirm they were provided with information on complaints and complaints forms and can describe having a concern addressed immediately.

Three written complaints in 2013 were reviewed (one in March and two in May). 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: FA**

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 documented in January 2013 that has set specific quality goals for Bupa Riverside including customer satisfaction and retention, service performance, operational effectiveness, financial performance and HR development. The quality plan has been reviewed in May and August 2013 with progress against objectives documented.

Bupa Riverside provides care for up to 65 residents across rest home and hospital service levels. There are 16 of 40 occupied rest home beds and 17 of 25 hospital beds occupied at the time of audit. There are no residents under the 'medical' component of their certificate, two identified as under the age of 65 years (one hospital and one rest home) and one respite resident.

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) will also be 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.

Bupa Riverside has an experienced facility manager who is a registered nurse. She has been the facility manager at Bupa Riverside for approximately 10 months since Bupa purchased the service and has managed other aged care facilities within the region prior to this appointment. She has a Graduate Diploma Business Studies. She is supported by a Clinical Nurse Manager (RN). There are job descriptions for both positions that include responsibilities and accountabilities. The operations manager provides onsite support for the facility and nurse managers and there is a monthly teleconference with all facility manager in the region.

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 and rest home (certificates sighted).

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

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 managers role.

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 operations manager also provides support in the absence of the facility manager as confirmed by the operations manager interviewed.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Bupa Riverside has a quality and risk management system. Interviews with managers and staff including the facility manager, clinical nurse manager, quality coordinator/RN, two registered nurses, four caregivers, divisional therapist and cook and review of meeting minutes 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 2 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.

The document control policy (321) includes; a) responsibilities - policy development, b) approval of policies, c) responsibilities - policy implementation, d) document control register, e) document design, f) document properties, g) developing a new policy, and h) reviewing an existing policy.

A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. 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, as appropriate, feedback from the committee and other technical experts. Policies and procedure documents are reviewed regularly. It is the organisation's aim to ensure that these are reviewed at least every three years. Policy review dates are monitored.

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 monthly staff meeting. The structure of meetings has been revised and as of September 2013, there are to be separate monthly meetings for support staff, health and safety, infection control, registered nurse and staff meetings as well as quality meetings and two monthly resident/family meetings.

There are 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 two units 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 an infection control register in which all infections are documented each month. Infection control rates, outbreaks and results of satisfaction surveys are reported to the care services team. The general manager quality and risk is kept informed and is part of the governing body.

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. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff meetings.

Staff meetings currently include all aspects of the quality and risk management programme including health and safety, restraint, IC, incidents and accidents, complaints.

There is an internal audit schedule implemented that 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. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes.

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 manager which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year.

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Bupa Riverside and document actions that have improved outcomes or efficiencies in the facility.

Corrective action plans are documented with evidence that issues are resolved with a second audit completed four to six weeks after the initial audit to ensure that issues have been addressed. There is an identified quality coordinator (registered nurse) who has a dedicated eight hours a week to oversee the audit process.

There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. There is a Bupa Health & Safety Plan for 2012 with two objectives that include the Bfit programme (for staff) and a reduction of incidents of behaviours that challenge. On-going review of these objectives for 2013 is seen in H&S meeting minutes.

D19.3 There are implemented risk management and health and safety policies and procedures in place including accident and hazard management.

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, sensor mats, landing pads, assessment and exercises by the physiotherapist as confirmed by the physiotherapist interviewed.

The facility health checks have been completed prior to the external audit including a check in March and July with recommendations implemented.

Residents and family interviewed confirm that the service has improved since the purchase of the service in October 2012.

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: FA

Risk level for PA/UA:

Finding Statement

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: FA

Risk level for PA/UA:

Finding Statement

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service collects incident and accident data. Category one incidents policy (044) states "The category one incident will be recorded on a standard accident/incident form. The form must provide: a clear account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence. The completed 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 now 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; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. 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.

22 incident forms were reviewed across the service and all demonstrated clinical follow up by the clinical nurse manager and monitoring (such as neuro obs and post falls assessment) having been undertaken when indicated.

D19.3c Bupa care services has a reportable event policy that sits with the category one (serious incidents) policy. This policy identifies the events that need to be reported, by whom and the process to follow. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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: FA	Risk level for PA/UA:
Finding Statement		
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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
A register of RN 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. Six of six staff files reviewed files had up to date performance appraisals and there is a signed contract in each file.

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 (two new caregivers) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. They described an orientation that included three to four shifts with a buddy and both received a copy of the staff handbook. Interviews with the RN who also holds a quality role and who provides oversight of education 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. (also 'Upraised' - aligned with their policy and procedures).

There is an annual education schedule that is being implemented. There are opportunities for registered nurses to access external education e.g. training available via the DHB. 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.

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 six of six 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. There are no nurses who have commenced on the Nursing Council Approved PDRP to date as Bupa Riverside has not yet owned the site for a year (set criteria will not have been met e.g. they must have had an annual performance appraisal prior to starting).

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); blood sugar levels and insulin administration, catheterisation, medication, first aid, floor washing, moving and handling, naso gastric tube care, nebuliser, oxygen administration, restraint, sub cutaneous fluids, syringe driver, van driving, wound management.

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 Ma 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 are a total of 35 staff including a facility manager, clinical nurse manager, seven registered nurses, 17 caregivers, one divisional therapist, one kitchen manager, three kitchen hands, one cook, two cleaners and two laundry.

Staffing numbers are over that described in policy.

Rosters sighted indicate that there is adequate staffing against resident numbers and acuity as follows:

Rest home: AM - two caregivers (one full shift and one until 12.30pm); PM - one full shift and one caregiver until 9pm.

Hospital: AM - two caregivers both full shifts; PM - One caregiver full shift and one until 9pm.

Night: Two caregivers and one RN across the service.

There is an RN on site at all times and a clinical nurse manager and facility manager full time from Monday to Friday.

Five of six residents and four of five family interviewed state that there is sufficient staff on site at all times.

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 storage for archived files.

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

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service.

Information gathered at admission is retained in resident's records. Six residents (three from the rest home and three from the hospital) and five family members interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents/families/whānau at entry. 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.

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission.

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

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

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. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

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 admission – role of caregiver policy, an admission – role of a registered nurse policy, an admission nursing assessment policy and an admission checklist.

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. Within three weeks the lifestyle care plan is developed in five of six files sampled (three from the rest home and three from the hospital) - one resident is on short term respite care and has not been at the facility for three weeks.

In six of six files sampled (three from the rest home and three from the hospital) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse (except that the resident on short term respite does not have a long term care plan). Medical assessments are completed on admission by the GP in five of six files sampled (one resident is on short term respite care) and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person.

Activity assessments and the activities sections care plans have been completed by a diversional therapist.

Six residents interviewed (three hospital and three rest home) stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed and up to date in all six resident files sampled.

D16.2, 3, 4: The six files reviewed (three from the rest home and three from the hospital), identified that in all six files an assessment was completed within 24 hours and five of six files identify that the long term care plan was completed within three weeks (one resident is on short term respite care). There is documented evidence that the care plan were reviewed by a RN and amended when current health changes (see CAR 1.3.5.2). Five of six care plans evidenced evaluations completed at least six monthly (one resident is on short term respite care).

D16.5e: Six 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 is to be seen three monthly.

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.

The care plan summary policy (371) states "the care plan summary is completed by the registered nurse within one week of admission. It is a summarised account of the cares a resident needs and will be used by caregivers to ensure care delivery is in line with the lifestyle care plan. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change)' . Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Six files identified integration of allied health and a team approach is evident in the six files. The GP interviewed spoke positively about the service and describes very effective communication processes.

All six files have at least an initial physiotherapy assessment with on-going assessments as necessary.

Tracer Methodology rest home:

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

Tracer methodology hospital:

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

Riverside has implemented the revised Bupa assessment booklets and lifestyle templates for all residents. The assessment booklet provides very in-depth assessment tools including; falls, Braden, skin, mini nutritional, continence, pain, dependency and activities. The falls assessment section also includes additional risk factors, for example; vision, mobility, behaviours, environment and continence.

Risk assessment tools and monitoring forms are reviewed at least six monthly and are used to effectively assess level of risk and required support for residents including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, MNA, incontinence assessment, behaviour assessment, pain assessment, skin assessment, dependency rating and wound assessment.

The following personal needs information is gathered during admission (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 consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse.

Six of six resident files sampled (three from the rest home and three from the hospital) 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 are comprehensive and include input from allied health. The assessment booklet includes input from team members.

Notes by GP and allied health professionals are evident in resident's files, significant events, communication with families and notes as required by registered nurses. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met.

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: PA Moderate

The sample of files reviewed included;

Hospital - one resident with high mental health needs, one resident with unintended weight loss and one resident with a pressure area.

Rest home - one resident on respite care, one resident with recurrent exacerbations of COPD and one resident who is a diabetic.

Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health with one exception. One of the six plans reviewed was last updated in November 2012 and the resident has had an increase in falls risk, unintended weight loss and started experiencing pain since this time. These issues are not addressed in the care plan and this is an area requiring improvement.

Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Assessments completed on admission are comprehensive. The long-term care plan is completed within three weeks with GP involvement within 48 hours.

Plans are well described and are reflected in the progress notes. All six residents' care plans reviewed on the day of the audit (three hospital, four dementia, two rest home) provide evidence of individualised support and intervention required.

Six residents interviewed (three hospital and three rest home) and five families interviewed (three from the hospital and two from the rest home) confirm care delivery and support by staff is consistent with their expectations. All needs identified in the assessment process were included in the care plans.

There is a long term lifestyle care plan that includes; a) hygiene, b) medical, c) skin and pressure area care, d) bladder and bowels, e) mobility, f) food and fluids, g) rest and sleep, h) communication, i) emotional well-being, j) spirituality, k) religion and culture, and l) activities.

Lifestyle care plans demonstrate service integration. The assessment booklet includes input from team members including the activities coordinator.

Notes by GP and allied health professionals, significant events, communication with families are included in the sample group of residents files.

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: PA

Risk level for PA/UA: Moderate

The sample of files reviewed included;

Hospital - one resident with high mental health needs, one resident with unintended weight loss and one resident with a pressure area.

Rest home - one resident on respite care, one resident with recurrent exacerbations of COPD and one resident who is a diabetic.

Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health with one exception.

Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Finding Statement

One of the six plans reviewed was last updated in November 2012 and the resident has had an increase in falls risk, unintended weight loss and started experiencing pain since this time. These issues are not addressed in the care plan and this is an area requiring improvement.

Corrective Action Required:

Ensure care plans reflect current needs and are updated when needs change.

Timeframe:

3 months

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: PA Low

Residents' lifestyle care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by the clinical manager. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The four 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. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Six residents interviewed (three from the rest home and three from the hospital) and five families interviewed (three from the hospital and two from the rest home) were complimentary of care received at the facility.

The lifestyle care plans reviewed were all completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers, five families interviewed, two registered nurses, the facility manager and the clinical nurse manager. There is a short-term care plan that is used for acute or short-term changes in health status.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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 and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 17 residents including four pressure areas (two grade two and two grade one). Thirteen of the 17 wounds have evidence of having been reviewed in the timeframe stated. Four have not and this is an area requiring improvement.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

The facility has registered nurse cover 24/7 and has an 'in service' education programme.

A record of all health practitioners practicing certificates are kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by an R.N.

Lifestyle care plans are goal oriented and reviewed six monthly (with one exception - see CAR 1.3.5.2). 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: PA

Risk level for PA/UA: Low

The lifestyle care plans reviewed were all completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers, five families interviewed, two registered nurses, the facility manager and the clinical nurse manager. There is a short-term care plan that is used for acute or short-term changes in health status.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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 and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 17 residents including four pressure areas (two grade two and two grade one). Thirteen of the 17 wounds have evidence of having been reviewed in the timeframe stated.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Finding Statement

Four of the 17 wounds have not been reviewed in the timeframe stated.

Corrective Action Required:

Ensure all wounds are reviewed within the timeframe stated.

Timeframe:

3 months

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a diversional therapist who provides activities for 25 hours per week. On the day of audit residents in all areas were observed being actively involved with a variety of activities. The programme is developed monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review/evaluated.

The programme includes networking within the community with social clubs, the RSA etc. On or soon after admission, a social history is taken and information from this 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 individual residents activities. There are recreational progress notes in the resident's file that the activity officers completes for each resident every month. 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 the hospital, participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.

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

Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur in four of five files sampled - one resident is on respite care - see CAR 1.3.5.2 relating to the other care plan not being up to date. There is at least a one- three monthly review by the medical practitioner.

There are short term care plans 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. From the sample group of residents notes the short term care plans are well used and comprehensive. Examples of STCPs i use included; infections, wounds, and unexplained weight loss.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

ARC: D16.3c: All initial care plans were evaluated by the RN 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

Of the sample group of notes all of the residents/patients had signed the informed consent and had copies of the Code of Rights. 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 and hospital specialists.

D16.4c; The service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care.

D 20.1 Discussions with registered nurses identified that the service has access to mental health services for older people, cultural specialists, speech language therapists, dietitians, physiotherapist and hospital specialists.

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 which is kept on the resident's file. This was sighted in one resident files (from the rest home) where the resident had been transferred to hospital acutely. 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.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

Medications are managed appropriately in line with accepted guidelines. The medications are stored in a locked trolley used for both the rest home and hospital wings. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses administer medications who have passed their competency administer medications.

The service uses four weekly robotic packs. Medication charts have photo ID's. 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 sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Registered nurses are peer reviewed annually and trained in medication administration and competency checked annually. Only those staff deemed competent administer medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off.

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 was held in April 2013.

There are currently two residents self-administering at Riverside.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart in 10 of 16 medication charts sampled. This is an area requiring improvement. The controlled drug register indicates that weekly controlled drug checks have not always occurred and this is also an area requiring improvement. 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.

The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the residents' general practitioner at least three monthly. Charts are easy to read and current. Medication audits are completed six monthly.

D16.5.e.i.2; 16 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Opportunity for improvement: The service could consider having the controlled drug register index up to date to allow ease when administering controlled drugs.

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: Moderate

Medications are managed appropriately in line with accepted guidelines. The medications are stored in a locked trolley used for both the rest home and hospital wings. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses administer medications who have passed their competency administer medications. The service uses four weekly robotic packs. Medication charts have photo ID's. 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 sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Finding Statement

(i) Six of 16 medication administration sheets sampled have medication that is prescribed regularly but is not always signed as administered regularly. (ii) Controlled drug checks have not always occurred weekly.

Corrective Action Required:

(i) Ensure medications are administered as prescribed. (ii) Ensure controlled drug checks occur weekly.

Timeframe:

3 months

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 Mal 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, last in May 2013.

The service employs four kitchen staff including two cooks. The main kitchen supplies meals for the entire service.

All of the kitchen team at Riverside have completed food safety certs.

The service has a large workable kitchen that contains 1 walk-in pantry, freezer, a walk in chiller, an air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number audits completed include; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit.

The kitchen has recently developed large print menus with pictures of the main meal each day to make them more able to be understood by residents.

There is a nutrition - assessment and management policy (347) and a weight management policy (079).

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 care plan review. 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 and diabetics.

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, freezer, bain marie and dishwasher are maintained.

All kitchen staff have completed food-handling certificates.

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 "Masterchef" 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 PowerPoint's 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. This was described by the cook.

D19.2 Staff have been trained in safe food handling.

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 Ma 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 conducted in November 2012 around 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. Chemicals are labelled.

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: PA Low

There is a maintenance person who works a total of 24 hours per week. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 15 December 2013. Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen 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.

Hot water temperatures are monitored weekly and maintained at or just below 45 degrees Celsius. In July 2013 there was an incident where a resident was burnt by hot water. Investigation showed the tempering valve had broken and this was repaired by a plumber before the area was used again.

The facility has undergone significant refurbishment since the previous audit and this continues. There are eight rooms currently closed for renovation and a further four closed as they are storing furniture and equipment. There are a number of areas of paintwork, ceiling panels, carpet and one broken window that require repair and are included in the planned refurbishment. This is an area requiring improvement.

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 safe and there is shade.

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: PA	Risk level for PA/UA: Low
All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen 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.		
Finding Statement		
There are a number of areas of paintwork, ceiling panels, carpet and one broken window that require repair and are included in the planned refurbishment.		
Corrective Action Required:		
Ensure all areas of the building requiring repair are included in the planned refurbishment.		
Timeframe:		
6 months		

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The facility has 2 RH and 1 Hosp unit (The older part is closed currently due to refurb). There are showers and toilets throughout the facility. There are adequate Visitor and staff toilet facilities available. Communal toilets and bathrooms have appropriate signage and shower curtains installed. Six residents interviewed (three hospital and three rest home) report their privacy is maintained at all times.

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 Mal 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. Four caregivers from across each area report that rooms have sufficient rooms 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 is a large lounge and large separate dining room that is shared by rest home/hospital residents. There are two further lounge areas and a recreation room. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and six 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 Ma 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 cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed twice a year and last done July 2013 (100%). An environmental hygiene - cleaning audit was last completed in July 2013 (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. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

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. Staff training in fire safety February 2013. Fire evacuations are held six monthly. A fire evacuation was last held on 6 March 2013.

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 11 July 2013.

The facility is well prepared for civil emergencies and has emergency lighting and BBQ's. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. 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 radiators and ceiling heating which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored.	
Six residents interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident's rooms.	

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 Mal 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 three residents on the register. The files reviewed of two residents identified as having an enabler in the form of a bedrail with one also having a lap belt included a comprehensive enabler assessment that covered alternatives and least restrictive options.

The service currently has three residents requiring a bedrail that has been 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.

The operations manager interviewed states that her focus is on supporting the service to reduce the number of residents using restraint through implementation of other strategies and is planning to work with the clinical nurse manager to do this.

The physiotherapist interviewed on the day of the audit was trying to work with registered nurses to establish alternative strategies to restraint.

The service is currently working with one resident to take the bedrail off given that it is not serving any purpose any more. The family member is coming into discuss with the restraint coordinator (registered nurse).

A resident interviewed who uses enablers (bedrail and lap belt) states that she has verbally given consent to using the equipment but is not able to sign the consent form.

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 Mal 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 and review of signed job description identified understanding of the role.

The four caregivers interviewed are familiar with requirements of using restraint as per policy.

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.

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. A registered nurse is the restraint coordinator. There is a job description in place and signed and dated.

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 bedsides/low beds 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 (currently no residents with challenging behaviour).

Assessments are completed as required and to the level of detail required for the individual residents.

A restraint assessment form is completed for those residents requiring restraint. One restraint file was reviewed. It included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed 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 a registered nurse 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) and/or family and the facility restraint coordinator.

Restraint use is reviewed at least three monthly within the facility restraint meeting and also as part of 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 residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of one resident with restraint identified observations and monitoring. Restraint use is reviewed through the three monthly restraint meetings and six multi-disciplinary meeting and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint.

There is training programme in place that has provided staff with workshops around behaviours that challenge (October 2012 and July 2013), dementia (October 2012 and July 2013) and restraint (September 2012 and July 2013). The staff interviewed including the four caregivers are able to describe use of restraint in a safe manner.

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 six monthly 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: FA

Individuals approved restraint is reviewed at least three monthly through the restraint meeting and as part of six multi-disciplinary review with family 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 is proactive in minimising restraint. Bupa analysis for 2011 has been shared with the restraint coordinators across the organisation. They started the year off with a rate of 3.4 (297 people being restrained) and finished on 2.8 (256 people being restrained). This is a 14% reduction in raw numbers for the year. The group has achieved great results over the past 3 years - to achieve this sort of sustained reduction, takes a huge culture shift in staff, and consistent education, support and guidance from senior staff. Further analysis identified that a) no-one being restrained in any rest home unit since April 2011, b) another year with no restraint use in dementia, c) steady reduction in hospital and PG units over the year, d) hospital rate of restraint reduced over 2011 from 6.6 down to 5.0, e) psycho-geriatric rate of restraint reduced over 2010 from 7.1 down to 5.9, f) sharing success – they now have 10 (22%) of their care homes as restraint free.

The operations manager and the facility manager along with the clinical nurse manager and the restraint coordinator are looking at ways of becoming restraint free.

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: FA

Risk level for PA/UA:

Finding Statement

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 Ma 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 G.P's, Southern Community Lab, the infection control and public health departments at the local DHB. Infection control is discussed regularly in the monthly registered nurse meetings. It is also discussed in the caregiver and quality 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. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

There have been no outbreaks.

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 policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings occur monthly. The infection control committee meets as part of the registered nurse meeting.

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, the clinical manager (IC coordinator), registered nurses and other staff. The facility also has access to an infection control nurse, public health, G.P'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.

Other policies included (but not limited to) a) definition of infection for surveillance, b) infection control programme description, c) standards for infection control practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI's, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases.

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 coordinator is responsible for coordinating/providing education and training to staff. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist 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 29 May 2013. 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: FA

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.

There are standards for infection control practice – cleaning, food service, linen service, and waste management.

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.

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: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe: