**Bupa Care Services NZ Limited - Redwood Home & Hospital**

**Current Status:** **30-Sep-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**

Redwood is part of the Bupa group. The service provides hospital (geriatric and medical), rest home, and dementia and psychogeriatric level care. The service has a capacity of 64 residents. On the day of the audit there were 19 hospital residents, eight rest home residents, 14 residents in the dementia unit and nine residents in the psychogeriatric unit. Redwood is managed by a manager who has been in the role at Redwood for over two years. The manager also manages another Bupa aged care facility in Rotorua. She is also supported by a clinical manager and a Bupa operations manager.

Improvements are required related to incident reporting, dementia training, and aspects of care planning interventions, medication documentation and fridge temperature monitoring.

**Audit Summary AS AT** **30-Sep-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

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| **Consumer Rights** | Day of Audit30-Sep-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** |

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| **Organisational Management** | Day of Audit30-Sep-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit30-Sep-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** |

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| **Safe and Appropriate Environment** | Day of Audit30-Sep-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit30-Sep-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** |

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| **Infection Prevention and Control** | Day of Audit30-Sep-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** **30-Sep-13**

**Consumer Rights**

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

**Organisational Management**

Redwood has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric /mental health services. Redwood is benchmarked in all four of these. Benchmarking and audit data demonstrate that they have achieved good standards of care and service. Quality actions have resulted in a number of quality improvements for both residents and staff. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. There is an improvement required to ensure all staff working in the dementia units complete required dementia standards as per DHB contract.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff providing feedback on staffing and rostering.

**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.

The sample of residents’ records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. 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, turning charts and wound management.

Medication policies reflect legislative requirements and guidelines. 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 are improvements required around signing sheet documentation and as required medication prescribing.

The activities programme is facilitated by an activities team and residents and families report satisfaction with the activities programme. The programme includes significant community engagement including competitions with other aged care facilities in the area. An activities plan is developed by the activities coordinator for the dementia and psychogeriatric units and this is mostly implemented by caregivers.

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. There is an improvement required around ensuring that all food in fridges and freezers is dated and labelled.

**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. This audit has assessed four rooms which were previously used for dementia care as suitable for psychogeriatric care. There rooms are within the psychogeriatric unit locked area and are suitable for use for psychogeriatric residents. 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. 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 is 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 is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has remained restraint and enabler-free since June. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

**Infection Prevention and Control**

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training and is supported by the Bupa quality and risk team. Infection control training is provided at least twice each year for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

**Redwood Home & Hospital**

Bupa Care Services NZ Limited

Certification audit - Audit Report

Audit Date: 30-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

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

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Redwood Home & Hospital | 429 Te Ngae Road | Owhata | Rotorua  |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| This audit has assessed four rooms which were previously used for dementia care as suitable for psychogeriatric care.  |

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| **Type of Audit** | Certification audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 30-Sep-13 **End Date:** 30-Sep-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | RCompN, Health audit cert | 14.50 | 6.00 | 30-Sept-13 to 1-Oct-13 |
| Auditor 1 | XXXXXXX | RCompN, Health audit cert | 14.50 | 5.00 | 30-Sept-13 to 1-Oct-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| XXXXXXX | XXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 29.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 41.00 |
| **Staff Records Reviewed** | 8 of 66 | **Client Records Reviewed** *(numeric)* | 8 of 50 | **Number of Client Records Reviewed using Tracer Methodology** | 4of 8 |
| **Staff Interviewed** | 11 of 66 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 7 |
| **Consumers Interviewed** | 7 of 50 | **Number of Medication Records Reviewed** | 16 of 50 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 15 day of October 2013

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

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

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

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

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

# Services and Capacity

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| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Redwood Home & Hospital | 64 | 50 |       | 🞏 | 🗷 | 🗷 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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1.4 Safe and Appropriate Environment

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2 Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has remained restraint and enabler-free since June. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

3. Infection Prevention and Control

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Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | 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 |

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| 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: 0Criteria (of 48): CI:0 FA:23 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | 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 | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 5 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:20 PA:2 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Moderate | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 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 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 1 PA Mod: 3 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:17 PA:4 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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

1. 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 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

|  |
| --- |
| 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: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 5 **CI:** 0 **FA:** 39 **PA Neg:** 0 **PA Low:** 3 **PA Mod:** 3 **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:** 87 **PA:** 6 **UA:** 0 **N/A:** 8 |

# Corrective Action Requests (CAR) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:30-Sep-13 End Date: 30-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.4 | 1.2.4.3 | PALow | **Finding:**Incident forms reviewed for August 2013 identified gaps on the hospital and rest home incident forms, follow up assessment not routinely documented on the incident forms (four rest home, one PG, five rest home), not all incident forms identify the writer/designation (four rest home, two hospital). Preventative opportunities or quality improvements in relation to incidents are not routinely documented on forms or in meeting minutes (noting: there are some QI-CAPs that had been completed when stats are above the benchmark). **Action:**Ensure incident forms are fully completed, follow up assessment documented, the writer and designation identified and opportunities for improvement identified (where able) | 3 months |
| 1.2.7 | 1.2.7.5 | PALow | **Finding:**ARC E4.5f ARHSS D17.11d There are 16 caregivers that work in the dementia units. Seven have completed the required dementia standards, five are in process and four have commenced but have not been active for the last six months.**Action:**Ensure all staff that work in the dementia units have completed the required dementia standards as per ARC and ARHSS contract. | 6 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.5 | 1.3.5.2 | PAModerate | **Finding:**(i) One resident with a recent fracture has a short term care plan but this does not document increased assistance required with ADL's. (ii) One resident has had three recent pressure areas. The short term care plans for the first two pressure areas do not include interventions around pressure area risk management and nutritional requirements. There is no short term care plan for the current pressure area. (iii) Five of eight care plans do not have interventions relating to all identified areas of need. Examples include pain management, pressure area risk management, challenging behaviours, management of hyper and hypoglycaemia for a diabetic on insulin and falls management. (iv) One resident has documented on an incident form that he requires supervision showering. This information has not been transferred to the care plan.**Action:**(i) Ensure short term care plans include all relevant needs. (ii) Ensure pressure area care plans include all required interventions and that short term care plans are developed for every resident with a pressure area. (iii) Ensure care plans document interventions for all identified needs. (iv) Ensure care plans are updated when needs are identified following incidents. | 3 months |
| 1.3.6 | 1.3.6.1 | PAModerate | **Finding:**(i) Two of six two hourly turning charts sighted have periods of significantly longer than two hours when the resident has not been turned. (ii) Seven of 13 current wounds including one pressure area have not been reviewed within the stated timeframe.**Action:**(i) Ensure that two hourly turns when the need for this has been identified occur regularly and are documented. (ii) Ensure that all wounds are reviewed within the stated timeframe. | 3 months |
| 1.3.12 | 1.3.12.1 | PAModerate | **Finding:**(i) Twelve of 16 charts sampled have PRN medications charted with no indication for use documented. Examples include olanzapine, risperidone and Oxycontin. Two of these PRN medications do not document how often they should be given or a maximum dose.(ii) Six of 16 charts sampled have regular non-packaged medications charted that are not signed as administered regularly. (iii) Regular weekly controlled drug checks have not always occurred in the hospital.**Action:**(i) Ensure PRN medications document indication for use and how often they should be used. (ii) Ensure medications are administered as prescribed. (iii) Ensure regular weekly controlled drug checks occur. | 3 months |
| 1.3.13 | 1.3.13.5 | PALow | **Finding:**(i) There is unlabelled and undated food in the chiller and freezer in the kitchen. There is a jug of unlabelled, undated food in the hospital dining room fridge. **Action:**(i) Ensure all food in fridges and freezers is labelled and dated.  | 6 months |

# Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:30-Sep-13 End Date: 30-Sep-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 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and COR competency questionnaires. Interviews with four caregivers across each area showed an understanding of the key principles of the code of rights. Training provided May 13 (14 attended).

**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 seven residents (three hospital, four 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 seven relatives (four hospital, two dementia, one PG) confirmed they are informed of the code of rights and this is also discussed at resident/relative meetings.

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

ARHSS D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

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

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

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

The confidentiality and resident privacy policy states the manager is the privacy officer. Privacy and communication training was Feb 13 (16 staff attended).

During the tour of the facility respect for privacy and personal space was demonstrated. Resident files are held in the rest home, dementia, psychogeriatric and hospital locked cupboards. Interview with caregivers could explain ways resident privacy is maintained. Interviews with seven residents confirmed that privacy is ensured. The Aug 13 resident satisfaction survey identified that 94% residents/relatives stated privacy was either excellent or good.

Resident information includes Bupa vision and values. Discussions with residents and relatives were positive about the service in respect of considering and being responsive to meeting values and beliefs.

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

Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, meal times and meal alternatives, specific culture alternatives) and that staff are obliging around choice. Care plans reviewed identified specific individual likes and dislikes. Caregivers from across each area 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 Aug 13 resident satisfaction survey, 90% of residents stated excellent or good.

A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training was last delivered in March 13 (38 staff attended).

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

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.

E4.1a: Two families interviewed from the dementia unit stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

ARHSS D4.1b Two PG resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

**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. Redwood 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 the home. This could be described by staff, residents and families interviewed.

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 is currently nine residents that identify as Maori at Redwood [four files reviewed of residents that identified as Maori included cultural consideration/needs and involvement of whanau].

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 relatives and all identified that values and beliefs were considered. Discussion with seven residents all stated that staff took into account their culture and values.

D3.1g The service provides a culturally appropriate service by ensuring cultural requirements of the residents are understood and considered when providing care to residents..

ARHSS D4.1d:Two PG 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. Enrolled nurses work under the direction and supervision of registered nurses. There is policy to guide staff practice: Gift, Gratitude’s and Benefits, Delegations of Authority. Qualified nurses meeting (monthly) includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. The code of conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. The one enrolled nurse works under the direction and supervision of registered nurses. There is policy to guide staff practice: Gift, Gratitude’s and Benefits, Delegations of Authority. Interviews with three qualified staff described professional boundaries.

ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two PG caregivers could describe how they build a supportive relationship with each resident. Interviews with one family from the PG unit confirmed the staff assist to relieve anxiety.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

**How is achievement of this standard met or not met? Attainment:** 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, and psychogeriatric/mental health services. Redwood is currently benchmarked in four areas (hospital, rest home, dementia, psychogeriatric). A quality improvement programme is implemented that includes performance monitoring. Graphs and data is provided to Redwood staff on the noticeboard and there are examples of corrective actions completed when trends are evident or areas are above the benchmark, i.e.: pressure areas were above the benchmark in April 2013 in the hosp. A quality action form has been established. 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 has robust quality and risk management systems and these are implemented at Redwood supported by a number of meetings held on a regular basis.

ARC A2.2 Services are provided at Redwood that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. ARC D1.3 all approved service standards are adhered to.

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

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

Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Redwood. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), Redwood is part of this. There is a dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting.

ARC D17.7c There are implemented competencies for care workers, enrolled nurses and registered nurses. Standardised annual education programme, core competency assessments and orientation programmes have been implemented at Redwood. Competencies are completed for key nursing skills at Hayman including (but not limited to); a) moving & handling, b) wound care, c) sub cut fluids, d) assessment tools and e) medication. RNs have access to external training.

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

Discussions with seven residents and seven relatives were positive about the care they receive.

Redwood Home & Hospital has undergone a transformation in relation to presentation both internal and external over the past two years. The large lounge now provides destination points where residents can choose to read in their sun filled library corner, watch TV, play pool or just sit. Gardens have been developed with good results; families noticing the improvements have gifted bulbs and roses. Their resident satisfaction survey showed an increase in overall satisfaction from 77% in 2011 to 83% for 2012. Residents also indicated an improvement in food service and delivery over the same period from 64% to 85%.

**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; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

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

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

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

The three registered nurses and one unit coordinator interviewed stated that they record contact with family/whanau on the family/whanau contact record.

Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for August 13 identified that in seven of nine hospital incident forms, seven of eight rest home, four of four dementia and seven of eight PG incident forms identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in April 2013 at Redwood with a result of 100%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

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

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

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

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

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. 'D11.3 The information pack is available in large print and advised that this can be read to residents.

ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new residents handbook providing practical information for residents and their families.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

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

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

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

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

Required consent forms and advance directive forms were evident on eight resident files reviewed (two from the rest home, two from the hospital, two from the dementia unit and two from the psychogeriatric unit).

Discussions with four caregivers interviewed (one from the dementia unit, one from the psychogeriatric unit, one from the hospital and one from the rest home) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with three registered nurses (two from the hospital and the unit coordinator from the psychogeriatric and dementia unit) identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

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

Completed resuscitation treatment plan forms were evident on all eight resident files reviewed. The service is working through ensuing all files evidence written discussion with family.

D13.1 There were eight admission agreements sighted and eight had been signed.

D3.1.d Discussion with seven families (two from the dementia unit, one from the psychogeriatric unit and four from the hospital) identified that the service actively involves them in decisions that affect their relatives lives.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with three registered nurses described how residents are informed about advocacy and support. There is a list of advocates on the resident noticeboard and one resident acts as the resident representative and speaks for other residents at the resident/family forum.

Interviews with seven residents (four hospital, two dementia, one PG) confirmed that they are aware of their right to access advocacy.

D4.1d; discussion with seven relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e, ARHSS D4.1f: the resident file includes information on resident’s family/whanau and chosen social networks.

The service has a Chaplin and is their nominated residents advocate and chairs resident meetings encouraging residents and their families to bring forward issues or concerns for discussion, one on ones or general resident discussion. The Chaplin is on site two days per week interacting with residents and their families.

**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; ARHSS D16.5f: All relatives interviewed stated 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. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with seven residents confirmed that the activity staff help them assess the community such as go shopping.

The following personal best examples were provided in regards to accessing the community providing Fijian style entertainment, visits with pets, designed and setup pamper area for residents, pyjama party for residents and families, and garden party for residents/families,

D3.1.e Discussion with four caregivers, two registered nurses and seven relatives that they are supported and encouraged to remain involved in the community and external groups.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

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 spreadsheet'.

There is a complaints flowchart. 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 seven residents and seven relatives confirmed they were provided with information on complaints. 2013 complaints were reviewed and included four verbal complaints. All were well documented including investigation, follow up letter and resolution.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

**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. Redwood has set specific quality goals for 2013 including (but not limited to); a) improve presentation of all catering services, b) implement actions based on information from the GPS that indicated where staff felt improvements could be made that would assist staff engagement.

Bupa Redwood provides hospital - medical/geriatric, rest home, dementia and psychogeriatric care for up to 64 residents. There were eight rest home residents, 19 hospital residents and 14 residents in the 15 bed dementia unit and nine of 10 residents in the psychogeriatric unit.

The organisation has commenced a Clinical Governance group. The committee is to continue meeting two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly.

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

The Facility Manager has a background in hospitality. The manager oversees one other Bupa facility (The Gardens) in the Rotorua area. She described being onsite for the morning and the afternoon at The Gardens. She has been in the role for over two years and is supported by an assistant manager and clinical manager.

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.

ARC E2.1, ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

**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:**

Bupa Redwood provides hospital - medical/geriatric, rest home, dementia and psychogeriatric care for up to 64 residents. There were eight rest home residents, 19 hospital residents and 14 residents in the 15 bed dementia unit and nine of 10 residents in the psychogeriatric unit. Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.

Redwood has set specific quality goals for 2013 including (but not limited to); a) improve presentation of all catering services, b) implement actions based on information from the GPS that indicated where staff felt improvements could be made that would assist staff engagement.

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

**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 manager’s role. The service is supported by the Bupa Operations Manager. There is a unit coordinator (RN) across the units.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to residents that require hospital (medical), rest home, dementia and psychogeriatric care. There are two residents under YPD contracts. There is a house GP that visits two mornings a week. A physiotherapist undertakes twice weekly visits.

The service consults with the Bupa dementia leadership group, physiotherapist, dietitian, and mental health for older people. .

ARHSS D4.1a: The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

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

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

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

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

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team.

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

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

Key components of the quality management system link to the monthly quality committee. 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. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home, dementia, psychogeriatric, hospital unit and staff incidents/accidents (link improvements identified 1.2.4.3). 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. There is a monthly IC committee meeting. 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. Health and safety committee meets monthly is also an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation.

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

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

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Redwood and document actions that have improved outcomes or efficiencies in the facility i.e.: food presentation. The service continues to collect data to support the implementation of corrective action plans eg: action plan for increase pressure areas in hospital April 2013. Responsibilities for corrective actions are identified.

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

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The competed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Bupa have a dedicated email address to send CAT ones to. This is manned by more than one specific person within the Q+R team. D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

Incident forms reviewed for August 13 (nine hospital incident forms, eight rest home, four dementia and 10 PG) demonstrated documented gaps on incident forms and follow up.

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:** PA **Risk level for PA/UA:** Low

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 competed form is forwarded to the Quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Bupa have a dedicated email address to send CAT ones to. This is manned by more than one specific person within the Q+R team. Incident forms reviewed for August 13 (nine hospital incident forms, eight rest home, four dementia and 10 PG) demonstrated documented gaps on incident forms and follow up.

**Finding Statement**

Incident forms reviewed for August 2013 identified gaps on the hospital and rest home incident forms, follow up assessment not routinely documented on the incident forms (four rest home, one PG, five rest home), not all incident forms identify the writer/designation (four rest home, two hospital). Preventative opportunities or quality improvements in relation to incidents are not routinely documented on forms or in meeting minutes (noting: there are some QI-CAPs that had been completed when stats are above the benchmark).

**Corrective Action Required:**

Ensure incident forms are fully completed, follow up assessment documented, the writer and designation identified and opportunities for improvement identified (where able)

**Timeframe:**

3 months

**STANDARD 1.2.7 Human Resource Management**

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

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

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

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

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

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

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, RN four weeks), during this period they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (four caregivers, two registered nurse, one unit coordinators, two ATs) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

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

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

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

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

Bupa is the first aged care provider to have a Council approved PDRP. The Nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At Redwood, one RN is in the process of completing their portfolio on the Bupa Nursing Council approved PDRP.

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

E4.5f . 65% of care staff are either enrolled or have completed dementia training. There are 16 caregivers that work in the dementia units. Seven have completed the required dementia standards, five are in process and four have commenced but have not been active for the last six months.

ARHSS D17.7 The activity therapists working across the special care unit have completed dementia training with the Bupa Dementia Care Advisor.

The clinical manager is a Career Force Assessor. Five RNs and six caregivers have attended external Fundamentals of Palliative Care training.

**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:** PA **Risk level for PA/UA:** Low

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings. At least two training sessions are held monthly. Toolbox talks held and staff been encouraged to participate.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training. Competency register was up to date at Redwood. 65% of care staff are either enrolled or have completed dementia training.

**Finding Statement**

ARC E4.5f ARHSS D17.11d There are 16 caregivers that work in the dementia units. Seven have completed the required dementia standards, five are in process and four have commenced but have not been active for the last six months.

**Corrective Action Required:**

Ensure all staff that work in the dementia units have completed the required dementia standards as per ARC and ARHSS contract.

**Timeframe:**

6 months

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether over and above hours.

At Bupa Redwood there is a facility manager, assistant manager and clinical manager (registered nurse) who work 40 hours a week. The facility manager works across two Bupa facilities in Rotorua.

There is an implemented staffing policy that meets current resident numbers. The service has special dispensation from the DHB for the 10 bed PG unit for shared registered nurse cover from the hospital/rest home wings at nights. All caregivers and nurses carry a phone overnight and nurses also carry a pager which allows for immediate response when required. There is a RN rostered across the AM and PM shifts in the PG unit and in the hospital. There is a RN at night across the facility. Caregivers interviewed across each area stated staffing overall was good and management replaced staff when short.

 Residents and family interviewed state that there are sufficient staff on duty although they noted that staff were very busy.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.

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

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

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

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation (link improvement 1.2.4.3). 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. Seven residents and seven 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.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

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

E3.1 Two resident files from the dementia unit were reviewed and all includes a needs assessment as requiring specialist dementia care.

**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 eight of eight files sampled.

In eight of eight files sampled (two from the hospital, two from the rest home, two from the dementia unit and two from the psychogeriatric unit) the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission by the GP in eight of eight files sampled 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.

Seven residents interviewed (three hospital and four 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 eight resident files sampled.

D16.2, 3, 4: The eight files sampled (two from the hospital, two from the rest home, two from the dementia unit and two from the psychogeriatric unit), identified that in all eight files an assessment was completed within 24 hours and all eight files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All eight care plans evidenced evaluations completed at least six monthly.

D16.5e: Eight resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

A range of assessment tools where 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. Eight files identified integration of allied health and a team approach is evident in the eight files. The GP interviewed spoke positively about the service and describes very effective communication processes.

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

ARHSS D16.6; Two residents with behaviours that challenge was reviewed from the psychogeriatric unit. Behaviours in both files were well identified through the assessment process, management plans implemented, short term care plans were developed for acute episodes of aggressive behaviour with evidence of regular evaluations.

Tracer Methodology hospital:

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

Tracer methodology rest home:

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

Tracer methodology psychogeriatric unit:

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

Tracer methodology dementia unit:

*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

Redwood have implemented the revised Bupa assessment booklets and care plan 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.

Eight of eight files sampled (two from the hospital, two from the rest home, two from the dementia unit and two from the psychogeriatric unit) 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.

ARC E4.2; ARHSS D16.5gii Resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed.

**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

Dementia - one resident

Rest home - one resident

Psychogeriatric unit - one resident

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

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. Overall residents' care plans reviewed on the day of the audit provide evidence of individualised support. However long term care plans for five of eight residents do not include all identified needs. One resident with a recent fracture does not have increased needs around ADL's documented in the short term care plan and one resident with two past short term care plans around pressure areas only has interventions related to wound management included in the short term care plans. This resident has had a third pressure area for which no short term care plan has been developed. One resident has documented on an incident form that he should be supervised showering and this had not been updated the care plan. These are areas requiring improvement.

Seven residents interviewed (three hospital and four rest home) and seven families interviewed (two from the dementia unit, one from the psychogeriatric unit and four from the hospital) confirm care delivery and support by staff is consistent with their expectations.

There is a long term 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.

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 resident’s files.

E4.3 Two resident files reviewed from the dementia unit identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, ARHSS 16.3g: Short term care plans are in use for changes in health status.

D16.3f; ARHSS D16.5f Eight resident files reviewed identified that family were involved.

ARHSS 16.3g: Two resident files reviewed (PG) identified current abilities, level of independence, identified needs and specific behavioural management strategies. Both residents had comprehensive behaviour management plans.

**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

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. Overall residents' care plans reviewed on the day of the audit provide evidence of individualised support.

**Finding Statement**

(i) One resident with a recent fracture has a short term care plan but this does not document increased assistance required with ADL's. (ii) One resident has had three recent pressure areas. The short term care plans for the first two pressure areas do not include interventions around pressure area risk management and nutritional requirements. There is no short term care plan for the current pressure area. (iii) Five of eight care plans do not have interventions relating to all identified areas of need. Examples include pain management, pressure area risk management, challenging behaviours, management of hyper and hypoglycaemia for a diabetic on insulin and falls management. (iv) One resident has documented on an incident form that he requires supervision showering. This information has not been transferred to the care plan.

**Corrective Action Required:**

(i) Ensure short term care plans include all relevant needs. (ii) Ensure pressure area care plans include all required interventions and that short term care plans are developed for every resident with a pressure area. (iii) Ensure care plans document interventions for all identified needs. (iv) Ensure care plans are updated when needs are identified following incidents.

**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 Moderate

Residents' care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by the clinical manager in all three areas. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The four caregivers interviewed (one from the dementia unit, one from the psychogeriatric unit, one from the hospital and one from the rest home) 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. Seven residents interviewed (three hospital and four rest home) and seven families interviewed (two from the dementia unit, one from the psychogeriatric unit and four from the hospital) were complimentary of care received at the facility.

The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers ,seven families interviewed, three registered nurses (two from the hospital and the unit coordinator from the psychogeriatric and dementia unit), the facility manager and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status (see CAR 1.3.5.2).

Two of six turning charts indicate that residents are not always turned two hourly (see 1.3.3). This is an area requiring improvement.

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 13 residents. This includes two pressure areas (see CAR 1.3.5.2 around care plans for pressure areas). Staff training around wound management occurred in April 2013 and 11 staff attended. Staff also attended training around pressure risk management in September 2013 with five staff attending. Seven of the 13 wounds have not been reviewed in the timeframe stated and this is also 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.

ARHSS D16.4;There is good specialist input into residents in the PG a unit. A mental health consultant visits as required, psychogeriatrician visits weekly and PDN visits weekly from mental health services for older people Strategies for the provisions of a low stimulus environment could be described.

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.

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:** Moderate

Residents' care plans are completed by the registered nurses or an enrolled nurse and checked and countersigned by the clinical manager in all three areas. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The four caregivers interviewed (one from the dementia unit, one from the psychogeriatric unit, one from the hospital and one from the rest home) 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. Seven residents interviewed (three hospital and four rest home) and seven families interviewed (two from the dementia unit, one from the psychogeriatric unit and four from the hospital) were complimentary of care received at the facility. The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers ,seven families interviewed, three registered nurses (two from the hospital and the unit coordinator from the psychogeriatric and dementia unit), the facility manager and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status (see CAR 1.3.5.2).

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 13 residents. This includes two pressure areas (see CAR 1.3.5.2 around care plans for pressure areas). Staff training around wound management occurred in April 2013 and 11 staff attended. Staff also attended training around pressure risk management in September 2013 with five staff attending.

**Finding Statement**

(i) Two of six two hourly turning charts sighted have periods of significantly longer than two hours when the resident has not been turned. (ii) Seven of 13 current wounds including one pressure area have not been reviewed within the stated timeframe.

**Corrective Action Required:**

(i) Ensure that two hourly turns when the need for this has been identified occur regularly and are documented. (ii) Ensure that all wounds are reviewed within the stated timeframe.

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

There are two activity officers. The activities coordinator provides activities in the hospital and rest home and plans activities for the dementia unit and psychogeriatric unit, most of which are run by the caregivers. The activities coordinator has training around dementia care and needs. On the day of audit residents in all areas were observed being actively involved with a variety of activities. Caregivers were witnessed to provide a varied programme in the dementia and psychogeriatric units. 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, schools 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 officer 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 all areas of the facility, participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.

Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit and psychogeriatric unit which are conducted by care staff out of normal hours. There is a resource cupboard in each of these units where caregivers (or visitors) can access activities to complete with residents.

The activities coordinator has attended Bupa training around providing activities in a dementia unit.

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

ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered is included in the lifestyle care plan. Residents are quick to feedback likes and dislikes to the activity officer. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

**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. There is at least a one- three monthly review by the medical practitioner. Care plans are evaluated by the registered nurses six monthly or when changes to care occur as sighted in eight of eight files sampled (two from the hospital, two from the rest home, two from the dementia unit and two from the psychogeriatric unit).

There are short term care plans to focus on acute and short-term issues (see CAR 1.3.5.2). Changes to the long term care plan are made as required and at the six monthly review if required. From the sample group of resident’s notes the short term care plans are well used and comprehensive. Examples of STCPs i use included; infections, wounds, challenging behaviours, and unexplained weight loss.

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

ARC: ARHSS 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 NASC, mental health services for older people, occupational therapists, speech language therapists, hospital specialists and dietitians.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident’s file. This was sighted in one resident files (from the rest home - see 1.3.3) 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 🗷 MaI 🞏 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 locked trolleys for each of the three wings (currently the hospital and rest home are combined). 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. Regular weekly controlled drug checks have not always occurred in the hospital and this is an area requiring improvement. Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications.

The service uses two 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 and enrolled nurses are peer reviewed annually and caregivers are selected by the clinical manager 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 with 12 staff attending.

Medication – self administration policy (098) states self –administration of medication will be documented in the residents care plan.

There are currently no residents self-administering at Bupa Redwood.

 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 for 10 of 16 medication charts sampled. This is 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.

There is a quality goal at an organisational level to reduce the use of antipsychotics. Advised this is progressing with currently 36% of the facilities total residents being on an antipsychotic medication. This includes PRN medication and they are monitoring their residents to enable them to remove the medication completely. At Bupa Redwood, the psychogeriatric unit has the highest percentage being at 92%. This is followed by the dementia unit which has 71%. The service is above the benchmark identified by Bupa and the service is actively working to reduce this with all residents using antipsychotics have an antipsychotic use plan to actively reduce antipsychotic use.

Twelve of 16 charts sampled have PRN medications charted with no indication for use documented. Examples include olanzapine, risperidone and Oxycontin. This is an area requiring improvement.

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

**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 locked trolleys for each of the three wings (currently the hospital and rest home are combined. 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. Regular weekly controlled drug checks have not always occurred in the hospital and this is an area requiring improvement. Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications.

The service uses two 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.

 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 for 10 of 16 medication charts sampled. 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.

There is a quality goal at an organisational level to reduce the use of antipsychotics. Advised this is progressing with currently 36% of the facilities total residents being on a medication. This includes PRN medication and they are monitoring their residents to enable them to remove the medication completely. At Bupa Redwood, the psychogeriatric unit has the highest percentage being at 92%. This is followed by the dementia unit which has 71%. The service is above the benchmark identified by Bupa and the service is actively working to reduce this with all residents using antipsychotics have an antipsychotic use plan to actively reduce antipsychotic use.

Four of 16 charts sampled have PRN medications charted with indications for use documented.

**Finding Statement**

(i) Twelve of 16 charts sampled have PRN medications charted with no indication for use documented. Two of these PRN medications do not document how often they should be given or a maximum dose.(ii) Six of 16 charts sampled have regular non-packaged medications charted that are not signed as administered regularly. (iii) Regular weekly controlled drug checks have not always occurred in the hospital.

**Corrective Action Required:**

(i) Ensure PRN medications document indication for use and how often they should be used. (ii) Ensure medications are administered as prescribed. (iii) Ensure regular weekly controlled drug checks occur.

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

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

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

The service employs seven kitchen staff including three cooks. The main kitchen supplies meals for the hospital/rest home, psychogeriatric unit and the dementia unit.

 Three of the seven on the kitchen team at Bupa Redwood have completed food safety certs. The other four staff in the kitchen have been at the service less than two months and are currently completing their training.

The service has a large workable kitchen that contains 1 walk-in pantry, freezer, Domestic fridge with snacks for dementia unit, walk in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area. There is unlabelled and undated food in the fridge and freezer in the kitchen and in the fridge in the east hospital wing lounge. This is an area requiring improvement.

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 6 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 produces 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, freezers, bain marie and dishwasher are maintained.

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.

E3.3f, ARHSS D15.2f: There is evidence that there is additional nutritious snacks available over 24 hours.

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:** PA **Risk level for PA/UA:** Low

The service has a large workable kitchen that contains 1 walk-in pantry, freezer, Domestic fridge with snacks for dementia unit, walk in chiller, 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 6 weeks. There are a number audits completed include; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit.

**Finding Statement**

(i) There is unlabelled and undated food in the chiller and freezer in the kitchen. There is a jug of unlabelled, undated food in the hospital dining room fridge.

**Corrective Action Required:**

(i) Ensure all food in fridges and freezers is labelled and dated.

**Timeframe:**

6 months

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

**STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

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

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

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

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

There is a maintenance person who works a total of 28 hours per week and on call. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 11 March 2014. Electrical equipment is checked annually and this was last completed in August 2013. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time, in August 2013. 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.

This audit has assessed four rooms which were previously used for dementia care as suitable for psychogeriatric care. There rooms are within the psychogeriatric unit locked area and are suitable for use for psychogeriatric residents.

Currently the rest home main wing is closed for refurbishment. Residents from this wing have either been accommodated in the hospital wing (four residents) or moved to a sister facility on a temporary basis (eight residents).

Redwood Home & Hospital has undergone a transformation in relation to presentation both internal and external over the past two years. The large lounge now provides destination points where residents can choose to read in the sun filled library corner, watch TV, play pool or just sit. Gardens have been developed with good results; families noticing the improvements have gifted bulbs and roses.

External and internal customers take pride in surroundings and are always interested in the photo board which highlights our residents involvement in activities and also the theme for the month.

Facility Managers office moved into public area to ensure ease of access for residents, their families and staff.

The reception area has been remodelled to create a professional entrance, new seating areas provided with area painted in light colours.

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

E3.4d, ARHSS D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. Interviews with caregivers from the PG unit confirmed there was adequate equipment.

E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; ARHSS D15.3b There is a safe and secure outside area that is easy to access.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

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

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

The facility has four wings ( hospital, rest home, a secure psychogeriatric unit and a secure dementia unit). 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. Seven residents interviewed (three hospital and four 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 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

The rooms are spacious it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. 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 are several large lounges in the hospital and large separate dining room that is shared by rest home/hospital residents. There are two lounges and a dining area in each of the psychogeriatric unit and the dementia unit. The lounge and dining area in the psychogeriatric unit are well able to cater for the extra four residents being approved in this audit. 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 seven residents interviewed report they can move around the facility and staff assist them if required.

ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

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

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

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

There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is currently done off site at a sister facility. This is due to the laundry undergoing a major refurbishment. There are dedicated cleaning staff. An environmental hygiene - cleaning audit was last completed in July 2013 (100%). Corrective actions required are followed through the quality/risk management and staff meetings. The cleaning room is a designated area and clearly labelled. Chemicals are stored in a locked room . All chemicals are labelled with manufacturer’s labels. There is sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

A labelling machine purchased to improve identification of residents clothing has assisted in reducing lost items for residents

**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 Feb 2013. Fire evacuations are held six monthly. A fire evacuation was last held on 30 August 2013.

There is a comprehensive civil defence manual and emergency procedure 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 20 November 2001.

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. During the tour of the facility residents were observed to have easy access to the call bells in their bedrooms. Residents interviewed stated their bells were overall answered in a timely manner. There are no call bells in the several lounge areas in the hospital wings. Staff report that residents who use these areas are not able to use bells independently and that they check these areas often. Email confirmation dated 1 October 2013 was sighted to show that the call bell system is being replaced in the hospital. The operations manager reports that the new call bell system will include call bells in all lounges.

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.

Seven 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 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

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

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

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service remains restraint and enabler free since June 2013. They have had limited restraint use over the last year.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

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

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

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

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

Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The regional committees 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 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.

A scabies outbreak March 13 which included four residents in the dementia unit was well managed and retained. The service had a special meeting, and an IC summary report completed. Families were informed, consents for treatment were obtained for all staff and residents in the unit and the scabies was successfully treated.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

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

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

The infection control committee is a small group including; (but not limited to) the clinical manager, a registered nurse (IC coordinator), and caregiver. The facility also has access to an infection control nurse, public health, community lab, GP's and expertise within the organisation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

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

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed a certificate in IC from Waireki. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, and Bug Control for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was held on March 13 (13 attended). Toolbox training sessions have also been provided around scabies, March 13 (link 3.1); and MRSA, Mar 13. All training is mandated by Bupa and evaluated by staff who attend. Records of the evaluations were sighted.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education in Bupa newsletters and resident forums.

**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.

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 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.

Improvement Note:

A review of clinical indicators identified that infections remain low. However, while the scabies was well managed and identified as a Cat 1, this was not identified through the benchmarking 'skin infections'. Corrective actions could be better documented where infections are above the benchmark, i.e.: three eye infections in the hospital in April.

**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:**