**Bupa Care Services NZ Limited - Sunset Lodge Rest Home & Hospital**

**Current Status:** **23-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**

Sunset Rest Home and Hospital is part of the Bupa group. The service is certified to provide hospital (geriatric and medical), rest home, and dementia level care. The service has a capacity of 95 residents. On the day of the audit there were 39 hospital residents, 34 rest home residents and 21 residents in the dementia unit. Sunset is managed by an experienced aged care manager, who is also supported by a clinical manager, and a Bupa operations manager. Staff turnover remains low. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Sunset. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service is commended for achieving five continued improvement ratings relating to good practice, quality initiatives/governance, implementation of quality system, education programme, and infection surveillance.

There is two improvements required (low risk) related to GP documentation of advance directives and medication charting.

**Audit Summary AS AT** **23-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 Audit23-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit23-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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Continuum of Service Delivery** | Day of Audit23-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 low risk** |

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| **Safe and Appropriate Environment** | Day of Audit23-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 Audit23-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 Audit23-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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

**Audit Results AS AT** **23-Sep-13**

**Consumer Rights**

Sunset 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). Sunset have a number of staff involved in the programme. Residents and relatives spoke positively about care provided at Sunset. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. There is an improvement required around discussion with families about medically indicated not for resuscitation orders. A continuous improvement rating has been awarded against best practice.

**Organisational Management**

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

**Continuum of Service Delivery**

The service has 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.

Medicines are managed and policies reflect legislative requirements. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There are improvements required around signing sheet documentation and GP charting.

The activities programme is well-structured and individualised to meet the needs of each individual resident. This includes activities for those residents under 65 years of age.

All food is prepared on site. Individual and special dietary needs are well catered for. Snacks are readily available between meals. Residents interviewed responded favourably when asked about the quality of the food that is served.

**Safe and Appropriate Environment**

The facility is well-maintained. Ample-sized lounge and dining areas provide space for residents to move freely. Exterior areas are well-maintained with a secure garden area located in the dementia unit. Resident rooms are personalised with residents bringing their own personal belongings.

A current Building Warrant of Fitness is displayed at the entrance of the facility. Hazardous risks are identified, and are either eliminated, isolated or minimised. All cleaning supplies are stored in locked cupboards. Staff hold current first aid and CPR certificates. A registered nurse is always available on site.

Security cameras are strategically located inside and outside of the facility. All windows have security locks that are checked each night by staff.

In the event of a disaster or a pandemic, emergency plans are in place with civil defence kits strategically placed throughout the facility and spills kits readily available. Fire drills take place every six months. Emergency water and food supplies are sufficient for a minimum of three days. Alternative power and gas barbeques are available at the facility.

Since previous audit, there have been some significant improvements as a result of a refurbishment in the corridors and the common lounge and dining areas in our kowhai and Kauri wings. New lighting was also installed in these areas. A new public corridor has been built in their main dining/activities and the heating and emergency lighting is being upgraded throughout the care home.

**Restraint Minimisation and Safe Practice**

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Organisational policy is aimed at using restraint only as a last resort. Staff receive regular education and training on managing challenging behaviours and restraint minimisation.

The service currently has 14 hospital-level residents who are using an approved restraint and two residents who are using bedrails as enablers. Residents who are using a restraint or an enabler undergo a full assessment prior to the restraint or enabler being implemented, which includes investigating alternative strategies. Family are consulted prior to restraint use. Restraint use is evaluated a minimum of three-monthly.

**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 (clinical manager) 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. A continuous improvement has been awarded around the infection surveillance programme and implementing quality improvements to minimise infections.

**Sunset Rest Home & Hospital**

Bupa Care Services NZ Limited

Certification audit - Audit Report

Audit Date: 23-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** |
| Sunset Rest Home & Hospital | 117-123 Boundary Road | Blockhouse Bay | Auckland |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 23-Sep-13 **End Date:** 24-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 | XXXXXXXX | RCompN, Health audit cert | 12.50 | 6.00 | 23-Sept-13 to 24-Sept-13 |
| Auditor 1 | XXXXXXXX | RCompN, Health audit cert | 12.50 | 6.00 | 23-Sept-13 to 24-Sept-13 |
| Auditor 2 | XXXXXXXX | RPhysio, Health audit cert | 12.50 | 6 | 23-Sept-13 to 24-Sept-13 |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 37.50 | **Total Audit Hours off site** *(system generated)* | 19.00 | **Total Audit Hours** | 56.50 |
| **Staff Records Reviewed** | 9 of 78 | **Client Records Reviewed** *(numeric)* | 10 of 94 | **Number of Client Records Reviewed using Tracer Methodology** | 4of 10 |
| **Staff Interviewed** | 22 of 78 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 10 |
| **Consumers Interviewed** | 8 of 94 | **Number of Medication Records Reviewed** | 20 of 94 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf 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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sunset Rest Home & Hospital | 95 | 94 | 29 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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All food is prepared on site. Individual and special dietary needs are well catered for. Snacks are readily available between meals. Residents interviewed responded favourably when asked about the quality of the food that is served.

1.4 Safe and Appropriate Environment

The facility is well-maintained. Ample-sized lounge and dining areas provide space for residents to move freely. Exterior areas are well-maintained with a secure garden area located in the dementia unit. Resident rooms are personalised with residents bringing their own personal belongings.

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2 Restraint Minimisation and Safe Practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Organisational policy is aimed at using restraint only as a last resort. Staff receive regular education and training on managing challenging behaviours and restraint minimisation.

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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 | CI | 1 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | PA Low | 0 | 2 | 1 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:0 CI:1 FA: 10 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:1 FA:21 PA:1 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | CI | 1 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | CI | 1 | 7 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | CI | 1 | 3 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:3 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:3 FA:19 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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

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

* 1. Safe and Appropriate Environment

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

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 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 | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 0 **CI:** 5 **FA:** 43 **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:** 0**Total Criteria (of 219) CI:** 5 **FA:** 94 **PA:** 2 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:23-Sep-13 End Date: 24-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.10 | 1.1.10.7 | PALow | **Finding:**Nine of the ten resuscitation plans were medically initiated 'resuscitation is not clinically indicated' orders from the GP. There is no evidence that this has been discussed with families.**Action:**Ensure that when a GP determines that resuscitation is not clinically indicated this is discussed with family. | 6 months |
| 1.3.12 | 1.3.12.6 | PALow | **Finding:**(i) Four of 20 medication charts sampled have regular non-packaged medications prescribed that are not always documented as administered regularly i.e.: inhalers/eye drops. (ii) Eighteen of 20 medication charts sampled have PRN medications charted but the indication for use is not always documented.**Action:**(i) Ensure medications are administered as prescribed. (ii) Ensure all PRN medications document the indications for use. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:23-Sep-13 End Date: 24-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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| **Std** | **Criteria** | **Evidence** |
| 1.1.8 | 1.1.8.1 | **Finding:**Bupa has robust quality and risk management systems and these are implemented at Sunset supported by a number of meetings held on a regular basis including (but not limited to); quality, staff, restraint, residents/relatives, RN/ENs, kitchen and health and safety. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes have been implemented at Sunset . Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. A residents/relatives association was also initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Minutes are available for residents at Sunset. 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. This could be described by the RNs interviewed at Sunset and relevant information is also discussed in the RN/EN meeting. The Bupa geriatrician provides newsletters to GPs. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Sunset - 88.5% of staff have attained bronze, 33.3% silver and 24.4% have achieved gold. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care. Sunset is monitoring antipsychotic usage and are currently running at 20%. Benchmarking results are provided and reviewed at Sunset. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Sunset. Through toolbox talks (sighted for an alert regarding a privacy breach). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting. Sunset is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints . QI corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. eg: Bruising above KPI in rest home Sept 12. Evaluation identified that three of four were secondary to a fall. Recommendations included ensuring STCPs were in place and evaluated, strategies to minimise falls for these residents, encourage good oral intake of fluids and food to maintain good integrity. Quality action forms are also established for areas that staff/management identify as requiring improvement. Each of the following have included actions and have been evaluated to show improvements. 2013 (but not limited to); H&S signage in each area, new policies ensure signage, audit outcome communication to RNs via emails, ensuring staff are aware of all new STCPs, new transfer plans & illustrated traffic lights, review of nursing fall-out chairs, increase activities for U65s.. Toolbox talks are routinely completed that link to benchmarking indicators in each of the three areas at Sunset including (but not limited to); incontinence management, pressure area care, writing discrepancies in CD register, LCP documentation, antipsychotic usage, scabies outbreak, norovirus outbreak. Outcomes were evaluated as a result of these toolbox talks through the QI- corrective action plans. The clinical nurse manager and facility manager also participates in the ADHB cluster group meetings two monthly- on falls prevention and pressure injury prevention. This is then passed back through training sessions for staff and this could be described by qualified staff. In 2012 Sunset achieved the highest results in Bupa NZ in the Global people survey, averaging 95%. In 2013 the Facility Manager and the Clinical Manager (on behalf of Sunset) were among 15 international finalists nominated for a Bupa breakthrough Awards and received the award for a significant culture change at the home. They attended the awards ceremony in Barcelona in July 2013. Sunset has also been part of a number of pilot schemes including (but not limited to); they are piloting the CCMS (Collaborative Care Management Solutions). This is an electronic health record and clinical case management plan which provides secure access and up to date resident information directly at the point of care. It enables information to be shared with other health care professionals eg: GP Sunset went live with this programme on 10 September. In 2011 they successfully implemented the Vitamin D programme and now all of their residents are on vitamin D. They were one of the first Bupa care homes to implement LCP and complete the training. They achieved 100% in a recent LCP file audit. They also participated in a 2012 New Zealand older people’s oral health survey. They piloted Bupa’s new IT citrix programme which has now been implemented across other Bupa Care homes. In 2011 the satisfaction rate from the resident survey for activities was 88%. In 2013 it was 93%. This improvement was achieved by employing a second fulltime activities person to increase and diversify the range of activities. The programme has now been extended to include external entertainers every Saturday.  |

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| 1.2.1 | 1.2.1.1 | **Finding:**Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Sunset is part of the northern 2 Bupa region which includes eight facilities. The managers in the region meet two monthly, teleconference weekly. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Sunset and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Sunset annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Sunset has implemented the "personal best" initiative whereby staff are encouraged to enhance the lives of residents. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans were rolled out in end 2011. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. In 2012 they have identified that they have achieved three out of four Quality Goals. Goal 1: To deliver best practice care to dying residents and their families in the last hours and days of life. The Liverpool care Pathway was established and staff were trained in its application. Two RNs have the role of LCP resource nurses and they organises educations for staff regarding palliative care one of them is also taking part in the Leadership course through BUPA. Both RN’s have also attended- National LCP Master Class in 2012 and the pain medication update-Feb 2013, Aged Residential Care Clinical Support Services 2013. The facility is part of research with the Auckland University around care provided of residents dying in residential care. Consent from families were obtained and a group have been surveyed. The service is currently waiting on the results of this survey. Goal 2; To improve the physical environment in the dementia wing. This was achieved by a complete repainting of the wing. Themed areas were created eg a nursery and a café corner. Outdoor furniture and gardening tools were provided. Satisfaction survey 2013 identified positive comments. Goal 3: To reduce Restraint by 20%. This was not achieved so the same Goal was set for 2013. Goal 4: To reduced Anti-Psychotic use by 20%. This was achieved and anti-psychotic use was reduced from 17 to 14. This goal was also set for 2013. The Quality Goals in 2013 include progress reporting and evaluation and YTD the following has been identified; a) Absenteeism has been reduced by 15%, b) antipsychotic use has been reduced from 17 to 12, c) restraint was reduced from 20 to 14 – this includes the use of fall-out chairs otherwise the total number of residents on restraint would be five. The quality team is also progressing towards reducing falls, skin tears and bruises by 15%. |

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| 1.2.3 | 1.2.3.6 | **Finding:**There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Sunset is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of clinical reports, quality reports tabled at meetings and discussion with the management team, there continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established on a regular basis in all three areas where Sunset is above the benchmark. i.e.: in July 13 skin tears were high across the hospital unit as a result a CAR was established which included (but not limited to) a RNs reporting and checking weekly and checking on skin conditions. The Goal to reduce skin tear by 25% by end of month. This was achieved as only three were reported in August. Sunset had several new initiatives in 2013. Most have been documented as ‘Quality Action Forms’, including (but not limited to) Anti-psychotic usage. Sunset has taken on board the BUPA drive for reduction in the use of anti-psychotics with their residents and on-going evaluation of effectiveness of anti-psychotics for those prescribed. Antipsychotic drug reduction strategies: education, GP ,RN and Clincial manager work in collaboration, follow up. Flag system on charts to alert staff to changes. The following improvements have been identified as a result of analysis of data. a) UTI prevention: Continence initiative: all residents with incontinence issue are on Flex products which advised have been very cost effective and residents are comfortable. Kitchen staff assisted in providing cranberry juice to the wings on a daily basis. This has been proven successful in their dementia wing where there is only one UTI YTD, and in the rest home-three YTD. b) Restraint initiatives: have identified restraint reduction implementation as a result of staff and family education, trial removal of restraint, lounge nurse routine implemented and perimeter guards in beds. c) The service has also identified improving care and quality of life of residents with dementia especially during the sundowning period - caregivers and DT are providing extra snack rounds and an organised activity especially to occupy residents (reduce resident behaviour) and reduce staff stress. Behaviour incidents remains low in benchmarking stats. d) imprest stock is counted once a week with CD’s to reduce medication error and expired meds. These have remained below the benchmark YTD. Insulin is only administered by RNs to minimise medication error, e) Wound dressings are monitored and dressed by the RNs and senior ENs only in order to minimise wound infection. The service has also introduced a flag system on charts to alert staff to changes and caregivers stated this is helpful. f) Resident file review, as per MDR plan every Wednesday to ensure all assessments are up to date and documentations are completed and meet the BUPA standards. g) Reflective writings and case study presentation at RN/EN meeting mainly to improve communication with resident/families and to provide the best care. The facility manager installed CCTV cameras in in common areas to monitor residents and for staff education. Advised by staff and management that this has been a great incentive and staff described some of the training sessions as a result. h) RN/CNM working with Dietitian to monitor residents weight and acting on it promptly if they are losing weight, and g) Communication books for Physiotherapist, RNs, Podiatrist, GP, FM report, and resident hospital appointments. RNs interviewed described that this has assisting integration of care.  |

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| 1.2.7 | 1.2.7.5 | **Finding:**The annual education programme includes two-three in-service sessions monthly. The service is also proactive around implementing toolbox training talks for staff as a result of incidents, complaints, feedback, observations, benchmarking results and internal audits (also link 1.2.3.6). The following toolbox talks have been provided in 2013 YTD including (but not limited to); a) falls prevention in the hospital (due to increased falls benchmarking),benchmarking results improved in April; b) pressure area care in the hospital in March 13 (due to increased pressure areas benchmarking), as a result these improved in April, c) writing discrepancies in controlled drug register (as a result of an incident), no further incidents were reported; Liverpool Care pathway documentation toolbox as a result of a file review, antipsychotic usage toolbox (link to organisational goal), scabies outbreak and norovirus outbreak.. Completed education is captured on electronic spread sheet, easily identifying attendance and capturing those ‘non-attenders.’ Records kept of staff that have read and signed sessions. Personal Best has been rolled out throughout the facility, and has been embraced by the staff. Education is also provided to residents and relatives through the regular newsletters and meetings. The management team also described a new initiative. In 2011 they piloted a numeracy and literacy programme for staff. 10 staff-completed this. Four of their cleaning staff were among those who completed it and who went on to undertake careerforce training. They are now nearing the completion of the foundation skills and Dementia unit standards.They were one of two Bupa care homes to participate in the University of Auckland’s palliative care research. The purpose of the research is to explore key factors in potentially avoidable admissions from aged residential care. This involved interviewing family members whose relative had died in an aged care facility. The manager advised that researchers will also be providing feedback to the facility as to the perceived experience which might identify gaps as well as identifying positive parts to the process. They are also piloting the CCMS (Collaborative Care Management Solutions). This is an electronic health record and clinical case management plan which provides secure access and up to date resident information directly at the point of care. It enables information to be shared with other health care professionals eg GP Sunset went live with this programme on 10 September. They were one of the first Bupa care homes to implement LCP and complete the training. They achieved 100% in a recent LCP file audit. |
| 3.5.7 | 3.5.7 | **Finding:**The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC stats are discussed at qualified staff meetings and corrective actions are implemented when infections increase. Incident/infection - analysis tool is utilised to assist with identifying trends. In July 13 an increase in respiratory tract infections in the hospital resulted in a QI-CAP being developed including (but not limited); increase temperature monitoring by RNs, increased fluids and supervision. There was no reported RTI in August. A QI-CAP was developed for the dementia unit for two wound infections May 13. Infection stats, trends and education are regularly provided via noticeboards and meetings to staff, residents and relatives. Other toolbox talks provided to staff included (but not limited to); scabies outbreak (10/6), norovirus outbreak (24/6), resp tract infections (11/5), infection control (18/9). A quality initiative has been implemented around UTI prevention: Continence initiative: all residents with incontinence issue use Flex products which has been very cost effective and residents are comfortable. Kitchen staff assisted in providing cranberry juice to the wings on a daily basis. This has been proven successful in their secure wing where there is only 1 UTI YTD, and in the Resthome-three YTD. The service is commended for the management of a norovirus outbreak in the dementia unit in June. A QI-CAP implemented identifies step by step actions taken, progress and evaluation. On-going toolbox talks, education, communication with family and fluid intake records maintained, staff were monitored closely for use of PPE, 4hrly TPR obtained for infected residents. Outbreak management meeting , caselog and IC special report completed. Twelve residents and one staff member infected. As a result of the implemented strategies, the infection was retained in the unit and lasted only one week.  |

**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) posters are clearly visible in multiple locations throughout the facility. A 'Code of Rights' Policy is implemented and staff can 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 nine caregivers ( three who work in the rest home, four from the hospital and two from the dementia unit) reflect an understanding of the key principles of the code of rights.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

The service provides information on their rights 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, the complaints procedure and advocacy information.

The service notice boards include 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 eight residents (five from the rest home and three from the hospital) identifies that they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Interviews with 10 relatives (five hospital, two rest home and three with family living in the dementia unit) confirm they are informed about the code of rights.

D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes information on: how to lodge a complaint, the code of rights pamphlet, and information on advocacy services provided by the Health and Disability Commissioner.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The confidentiality and resident privacy policy states the manager is the privacy officer. The policy includes confidentiality, privacy, collection of information, storage of information, and access to health information (disclosure). Privacy and communication training is in place for staff. The personal objects of significance policy outlines the process for the care of personal objects. During the tour of the facility respect for privacy and personal space was demonstrated. Resident files are held in each locked nurses’ office/station in each of the four facility wings (rest home, rest home/hospital, hospital and dementia). Care and support staff (nine caregivers, three RNs, five cleaners) can explain ways resident privacy is maintained. There is one shared double room in the hospital - curtains are used for privacy. The facility manager states only residents of the same sex with dementia share a room and only after consent is gained from their families. Residents in the shared room can be moved if incompatibility arises.

Interviews with eight residents (five rest home, three hospital) confirm that privacy is ensured.

The 2013 resident satisfaction survey identified that 97% of the residents stated privacy was either excellent or good. 97% of the respondents also reported that staff take the time to get to know them.

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

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

Residents and family members confirmed that they have adequate rights to choose within the constraints of the service (for example, meal times) and that staff are obliging around choice. Care plans reviewed identified specific individual likes and dislikes.

Nine caregivers (three working in the rest home, four in the hospital, two in the dementia unit) can 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 2013 resident satisfaction survey. 96% of residents stated it was either excellent or good.

A neglect and abuse policy (201) includes definitions and examples of abuse. Staff can describe these definitions. Relatives interviewed (five with relatives in the hospital, two in the rest home and three in the dementia unit) said that the care provided is very good and staff are very caring. Abuse and neglect training was last delivered in March and June 2013 with 60 of 78 staff attending training.

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 Three families with relatives living in the dementia unit state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a Ten 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 that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa’s facilities. The ADHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Bupa Sunset Rest Home and Hospital 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 as described by staff.

Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process. There is currently one resident that identifies as Maori. This resident file includes 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. The cultural assessment addresses the resident's family and friends, food, music, spiritual comfort, religion and identifies cultural events that are celebrated by the resident.

Six monthly multi-disciplinary team meetings are scheduled and occur to assess if the residents' needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life', which provides staff with a personal account of the resident. Discussions with ten of ten relatives all identified that values and beliefs of their family member are considered. Discussions with eight of eight residents all stated that staff took into account their culture and values.

Interviews with nine of nine caregivers confirm a variety of ways that they assist in meeting the cultural needs of the residents. Many residents are Indian and for those residents who cannot speak English, a Hindi-speaking staff is assigned to the resident for all three shifts, some staff bring in cultural foods for the residents as their 'personal best' initiative, the activities programme has musicians from a variety of cultures entertain the residents.

D3.1g The service provides a culturally appropriate service by completing thorough cultural assessments as part of the initial assessment process, documenting their 'map of life' and linking their cultural values and beliefs into the activities programmes that are provided. In addition, the kitchen provides culturally appropriate meals for residents (eg, vegetarian).

D4.1c Ten of the ten care plans reviewed include the resident’s social, spiritual, cultural and recreational needs.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

The 'Code of Conduct' is included in the employee pack of information, provided to them during their orientation to the service. Job descriptions include responsibility of the position. Signed copies of all employment documents were sighted in nine of nine staff files reviewed. Three 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 monthly nurses' meetings include discussions on professional boundaries and concerns. Management provides guidelines and mentoring for specific situations.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Sunset is currently benchmarked in three areas (hospital, dementia and rest home).

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

D1.3 all approved service standards are adhered to.

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

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

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

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

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

Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. Benchmarking data supports initiative development and there was a number at Sunset where Quality Indicator Corrective Action Plans have been established due to benchmarking being above the expected i.e.: raised KPI for increased pressure areas (3) in the hospital Aug 13. Action plan established which included progress, monitoring and evaluation and involved toolbox talks to staff. The goal was to reduce by 50% by end of Sept. To date in Sept there has been one reported pressure area (grade 1).

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. Two RNs have the role of LCP resource nurses and they organises educations for staff regarding palliative care. Both RNs are also taking part in the Leadership course through BUPA.

Standardised annual education programme, core competency assessments and orientation programmes have been implemented at Sunset. D17.7c.There are implemented competencies for careworkers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. Competencies are completed for key nursing skills at Sunset including (but not limited to); a) hoist/ manual handling, b) wound care, c) sub cut fluids, d) assessment tools, e) medications including nebulisers, BSLs/insulin, oxygen admin, syringe drivers, f) PEG feeds, catheter - female and male and g) first aid. All qualified staff at Sunset have current first aid certificates. All qualified staff at Sunset have completed LCP 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 five rest home, three hospital residents and five hospital, two rest home, three dementia relatives were positive about the care they receive. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s).

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

D1.3 all approved service standards are adhered to.

**Finding Statement**

Bupa has robust quality and risk management systems and these are implemented at Sunset supported by a number of meetings held on a regular basis including (but not limited to); quality, staff, restraint, residents/relatives, RN/ENs, kitchen and health and safety. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes have been implemented at Sunset . Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. A residents/relatives association was also initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Minutes are available for residents at Sunset. 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. This could be described by the RNs interviewed at Sunset and relevant information is also discussed in the RN/EN meeting. The Bupa geriatrician provides newsletters to GPs. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Sunset - 88.5% of staff have attained bronze, 33.3% silver and 24.4% have achieved gold. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care. Sunset is monitoring antipsychotic usage and are currently running at 20%. Benchmarking results are provided and reviewed at Sunset. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Sunset. Through toolbox talks (sighted for an alert regarding a privacy breach). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurse’s education day and education session at monthly meeting. Sunset is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints . QI corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. eg: Bruising above KPI in rest home Sept 12. Evaluation identified that three of four were secondary to a fall. Recommendation included ensuring STCPs were in place and evaluated, strategies to minimise falls for these residents, encourage good oral intake of fluids and food to maintain good integrity. Quality action forms are also established for areas that staff/management identify as requiring improvement. Each of the following have included actions and have been evaluated to show improvements. 2013 (but not limited to); H&S signage in each area, new policies ensure signage, audit outcome communication to RNs via emails, ensuring staff are aware of all new STCPs, new transfer plans & illustrated traffic lights, review of nursing fall-out chairs, increase activities for U65s.. Toolbox talks are routinely completed that link to benchmarking indicators in each of the three areas at Sunset including (but not limited to); incontinence management, pressure area care, writing discrepancies in CD register, LCP documentation, antipsychotic usage, scabies outbreak, norovirus outbreak. Outcomes were evaluated as a result of these toolbox talks through the QI- corrective action plans. The clinical nurse manager and facility manager also participates in the ADHB cluster group meetings two monthly- on falls prevention and pressure injury prevention. This is then passed back through training sessions for staff and this could be described by qualified staff. In 2012 Sunset achieved the highest results in Bupa NZ in the Global people survey, averaging 95%. In 2013 the Facility Manager and the Clinical Manager (on behalf of Sunset) were among 15 international finalists nominated for a Bupa breakthrough Awards and received the award for a significant culture change at the home. They attended the awards ceremony in Barcelona in July 2013. Sunset has also been part of a number of pilot schemes including (but not limited to); they are piloting the CCMS (Collaborative Care Management Solutions). This is an electronic health record and clinical case management plan which provides secure access and up to date resident information directly at the point of care. It enables information to be shared with other health care professionals eg: GP Sunset went live with this programme on 10 September. In 2011 they successfully implemented the Vitamin D programme and now all of their residents are on vitamin D. They were one of the first Bupa care homes to implement LCP and complete the training. They achieved 100% in a recent LCP file audit. They also participated in a 2012 New Zealand older people’s oral health survey. They piloted Bupa’s new IT citrix programme which has now been implemented across other Bupa Care homes. In 2011 the satisfaction rate from the resident survey for activities was 88%. In 2013 it was 93%. This improvement was achieved by employing a second fulltime activities person to increase and diversify the range of activities. The programme has now been extended to include external entertainers every Saturday.

**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 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. Fifteen of fifteen incident forms (two from the dementia unit and 13 across the hospital and rest home combined units) identify that family are notified.

As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was last completed in April 2013 with a result of 97 % compliance. 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 residents' files.

Residents' meetings are held two-monthly. Families are invited to attend. The diversional therapist leads the meetings and the manager attends. Meeting minutes documented reflect two-way communication (families/residents to management and management to families/residents).

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 (reference 1.1.6).

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.

D16.4b Ten of ten relatives state that they are always kept informed when their family members health status changes.

**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:** PA Low

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 ten resident files reviewed (five from the hospital, three from the rest home and three from the dementia unit).

Discussions with nine caregivers 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 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 10 resident files reviewed. However nine of the ten resuscitation plans were medically initiated 'resuscitation is not clinically indicated' orders from the GP. There is no evidence that this has been discussed with families and this is an area requiring improvement.

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

D3.1.d Discussion with 10 family identified that the service actively involves them in decisions that affect their relatives lives.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There is an advance directive policy. The Bupa care services resuscitation of residents 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 10 resident files reviewed. Nine of the ten resuscitation plans were medically initiated 'resuscitation is not clinically indicated' orders from the GP. The other is a not for resuscitation order signed by the resident who is competent.

**Finding Statement**

Nine of the ten resuscitation plans were medically initiated 'resuscitation is not clinically indicated' orders from the GP. There is no evidence that this has been discussed with families.

**Corrective Action Required:**

Ensure that when a GP determines that resuscitation is not clinically indicated this is discussed with family.

**Timeframe:**

6 months

**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) states ‘All residents will be informed of their right to an advocate' – information on the availability of advocacy services is held within the Admission Agreement.

The Health and Disability Advocacy services brochure is provided by the facility as part of the Admission Information Pack and is displayed in the facility'. Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry.

A Health and Disability Advocate is assigned to the facility. The manager reports she meets individually with residents and family and also attends residents' meetings. A new advocate has recently been appointed. Her name and contact details are posted in a visible location at the facility.

Interviews with nine caregivers, three registered nurses, the manager and the clinical manager describe how residents are informed about advocacy and support.

Interviews with eight of eight residents confirm that they are aware of their right to access advocacy services.

D4.1d; discussions with ten of ten family (five with a family member in the hospital, two in the rest home and three in the dementia unit) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

ARC D4.1e: Ten of ten residents' files include information on residents, family/whanau and chosen social networks.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

Consumers are able to maintain links with their family/whānau and their community.

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

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

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

D3.1h: Ten of ten relatives interviewed (five hospital, two rest home, three dementia unit) state they can 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 trips and going to the movies. Residents are assisted to meet their responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with eight of eight residents confirm that the activity staff help them access the community such as going on shopping trips.

The following personal best examples were provided in regards to accessing the community: arranging for a resident to go to the Stroke Club each week, arranging musical and dance events for the residents, and taking a resident on a weekend outing.

D3.1.e discussion with nine caregivers, two activities staff and ten relatives confirm that residents are supported and encouraged to remain involved in the community as they are able.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

Complaints received each month are reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart. D13.3h. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. A complaint management record is completed for each complaint.

A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with eight residents and 10 relatives confirmed they were provided with information on complaints and complaints forms. 2013 YTD complaints were reviewed and included two written complaints and one verbal complaint. All were well documented including investigation, follow up letter and resolution. There is one current HDC complaint that Bupa quality & risk team has completed a thorough investigation and provided documentation in regards to care of a resident on one day. Documentation has been forwarded to the HDC and the service is waiting to hear whether HDC will follow up further. A review of documentation identified comprehensive management of the care. However, the manager stated they have used the complaint as a 'learning experience' ,one RN completed a reflective practice and further tool box training sessions were provided to qualified staff as a result of the complaint.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Sunset has set specific quality goals for 2013 including (but not limited to); a) Reduce absenteeism by 15% from 4227 hrs. in 2012, b) reduce resident falls, skin tears and bruises by at least 15% , c) reduce restraint by at least 20% from 20, d) reduce anti-psychotic use by at least 20% - currently 17% of residents on medication..

Bupa Sunset provides hospital - medical, geriatric, rest home, dementia care and residential disability for up to 95 residents. The facility is divided into four units. There is a combined hospital/ rest home 27 bed unit (Kauri wing), occupancy included 12 hospital, five rest home. Kowhai wing is a 23 bed hospital unit, occupancy included 22 hospital and one rest home. Matai unit is a combined hospital/ rest home 24 bed unit, occupancy included five hospital and 18 rest home. The Rimu unit is a 21 bed secure dementia unit with full occupancy.

There are four residents under the medical component of their certificate (long term chronic contracts) and four residents under YPD contracts.

The service has a house GP that visits 2x weekly and as required and 2x physiotherapists that provide eight hours a week.

The organisation has a Clinical Governance group. The committee meets 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.

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.

Sunset has an experienced Facility Manager. Her background includes; 34 years’ experience in emergency services – police & ambulance. Frontline and line management. 14 years senior management experience and 5.5 years in aged care and management. She is supported by a Clinical Manager (RN). There are job descriptions for both positions that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

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

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

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

Bupa Sunset provides hospital - medical, geriatric, rest home, dementia care and residential disability for up to 95 residents. The facility is divided into four units. There is a combined hospital/ rest home 27 bed unit (Kauri wing), occupancy included 12 hospital, five rest home. Kowhai wing is a 23 bed hospital unit; occupancy included 22 hospital and one rest home. Matai unit is a combined hospital/ rest home 24 bed unit, occupancy included five hospital and 18 rest home. The Rimu unit is a 21 bed secure dementia unit with full occupancy.

There are four residents under the medical component of their certificate (long term chronic contracts) and four residents under YPD contracts. .

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

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

There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan.

Sunset has set specific quality goals for 2013 including (but not limited to); a) Reduce absenteeism by 15% from 4227 hrs. in 2012, b) reduce resident falls, skin tears and bruises by at least 15% , c) reduce restraint by at least 20% from 20, d) reduce anti-psychotic use by at least 20% - currently 17% of residents on medication.

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

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

**Finding Statement**

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes. Sunset is part of the northern 2 Bupa region which includes eight facilities. The managers in the region meet two monthly, teleconference weekly. A forum is held every six months (with national conference including all the Bupa managers). Quarterly quality reports on progress towards meeting the quality goals identified are completed at Sunset and forwarded to the Bupa and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Sunset annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Sunset has implemented the "personal best" initiative whereby staff are encouraged to enhance the lives of residents. The Bupa way has been launched in 2011 – the Bupa way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans were rolled out in end 2011. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. In 2012 they have identified that they have achieved three out of four Quality Goals. Goal 1: To deliver best practice care to dying residents and their families in the last hours and days of life. The Liverpool care Pathway was established and staff were trained in its application. Two RNs have the role of LCP resource nurses and they organises educations for staff regarding palliative care one of them is also taking part in the Leadership course through BUPA. Both RN’s have also attended- National LCP Master Class in 2012 and the pain medication update-Feb 2013, Aged Residential Care Clinical Support Services 2013. The facility is part of research with the Auckland University around care provided of residents dying in residential care. Consent from families were obtained and a group have been surveyed. The service is currently waiting on the results of this survey. Goal 2; To improve the physical environment in the dementia wing. This was achieved by a complete repainting of the wing. Themed areas were created eg a nursery and a café corner. Outdoor furniture and gardening tools were provided. Satisfaction survey 2013 identified positive comments. Goal 3: To reduce Restraint by 20%. This was not achieved so the same Goal was set for 2013. Goal 4: To reduced Anti-Psychotic use by 20%. This was achieved and anti-psychotic use was reduced from 17 to 14. This goal was also set for 2013. The Quality Goals in 2013 include progress reporting and evaluation and YTD the following has been identified; a) Absenteeism has been reduced by 15%, b) antipsychotic use has been reduced from 17 to 12, c) restraint was reduced from 20 to 14 – this includes the use of fall-out chairs otherwise the total number of residents on restraint would be five. The quality team is also progressing towards reducing falls, skin tears and bruises by 15%.

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

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

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

During a temporary absence, the clinical manager covers the manager’s role. The service is supported by the Bupa Operations Manager.

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

The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care to people who use the service including residents that require hospital (medical), rest home and dementia level care. The service consults with the Bupa dementia leadership group, LCP facilitator, physiotherapist, dietitian, and Nurse Specialist (ADHB).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

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

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

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

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

Key components of the quality management system link to the monthly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager and quality coordinator that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents; b) The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints; c) IC committee forms part of the quality committee. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. d) Health and safety committee meets two 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. e) The northern regional restraint approval group meets six monthly and the facility restraint group meets three monthly. These meetings include a comprehensive review of restraint/enabler use. Restraint internal audit is completed annually.

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

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

**Finding Statement**

There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Sunset is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of clinical reports, quality reports tabled at meetings and discussion with the management team, there continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established on a regular basis in all three areas where Sunset is above the benchmark. i.e.: in July 13 skin tears were high across the hospital unit as a result a CAR was established which included (but not limited to) a RNs reporting and checking weekly and checking on skin conditions. The Goal to reduce skin tear by 25% by end of month. This was achieved as only three were reported in August. Sunset had several new initiatives in 2013. Most have been documented as ‘Quality Action Forms’, including (but not limited to) Anti-psychotic usage. Sunset has taken on board the BUPA drive for reduction in the use of anti-psychotics with their residents and on-going evaluation of effectiveness of anti-psychotics for those prescribed. Antipsychotic drug reduction strategies: education, GP ,RN and Clincial manager work in collaboration, follow up. Flag system on charts to alert staff to changes. The following improvements have been identified as a result of analysis of data. a) UTI prevention: Continence initiative: all residents with incontinence issue are on Flex products which advised have been very cost effective and residents are comfortable. Kitchen staff assisted in providing cranberry juice to the wings on a daily basis. This has been proven successful in their dementia wing where there is only one UTI YTD, and in the rest home-three YTD. b) Restraint initiatives: have identified restraint reduction implementation as a result of staff and family education, trial removal of restraint, lounge nurse routine implemented and perimeter guards in beds. c) The service has also identified improving care and quality of life of residents with dementia especially during the sundowning period - caregivers and DT are providing extra snack rounds and an organised activity especially to occupy residents (reduce resident behaviour) and reduce staff stress. Behaviour incidents remains low in benchmarking stats. d) imprest stock is counted once a week with CD’s to reduce medication error and expired meds. These have remained below the benchmark YTD. Insulin is only administered by RNs to minimise medication error, e) Wound dressings are monitored and dressed by the RNs and senior ENs only in order to minimise wound infection. The service has also introduced a flag system on charts to alert staff to changes and caregivers stated this is helpful. f) Resident file review, as per MDR plan every Wednesday to ensure all assessments are up to date and documentations are completed and meet the BUPA standards. g) Reflective writings and case study presentation at RN/EN meeting mainly to improve communication with resident/families and to provide the best care. The facility manager installed CCTV cameras in in common areas to monitor residents and for staff education. Advised by staff and management that this has been a great incentive and staff described some of the training sessions as a result. h) RN/CNM working with Dietitian to monitor residents weight and acting on it promptly if they are losing weight, and g) Communication books for Physiotherapist, RNs, Podiatrist, GP, FM report, and resident hospital appointments. RNs interviewed described that this has assisting integration of care.

**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:** FA

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 now also introduced a dedicated email address to send CAT ones to. Manned by more than one specific person – that was described as an improvement within Bupa Q+R team. A monthly Cat One summary is also sent out to care homes.

D19.3b; 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.

Fifteen incident forms reviewed (two from the dementia unit and 13 across the hospital and rest home combined units) Incident forms all demonstrated clinical follow up by a registered nurse/clinical manager and monitoring (such as neuro obs) having been undertaken when indicated.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

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. Ten files reviewed files (two registered nurses, three caregivers, clinical manager, cook, diversional therapist) and all had up to date performance appraisals. All staff files included a personal file checklist.

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

Interviews with the Clinical Manager who is the main staff educator 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. Delirium and Dementia. 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.

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

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

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 There are 26 caregivers that work in the dementia unit. 25 have completed the required dementia standards and one (new staff member) is in process.

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

Sunset has a comprehensive annual education schedule which is adhered to and records of attendance for all staff are kept. There are at least three scheduled training sessions a month. Several education sessions are compulsory and all staff are expected to attend. Education topics and information is also displayed on the communication board for staff that are not able to attend to read. Toolbox talks held on a regular basis and staff been encouraged to participate. Compulsory education is repeated throughout the year at different times, to give all staff the opportunity to attend

Bupa has a comprehensive annual education schedule. All staff are encouraged to attend all education sessions. Compulsory education sessions are followed by tool box talks for staff unable to attend sessions. Senior Caregivers a H&S rep and has recently completed stage 1 H&S rep training

 All qualified staff have current first aid certificates.

All qualified staff have completed LCP training.

92 % of staff have completed Careerforce. 21 staff which include 12 existing staff, 5 new staff, 4 cleaners and the laundry work are currently enrolled in Career Force and are working through the foundation skills and dementia unit standards

There is a part time Quality Co-ordinator who is also a H&S rep and has completed Stage1 & 2 in H&S representative training.

Two RNs have the role of LCP resource nurses and they organises educations for staff regarding palliative care one of them is also taking part in the Leadership course through BUPA.

One RN has attended- National LCP Master Class in 2012, The pain medication update-Feb 2013, Aged Residential Care Clinical Support Services 2013.

The clinical nurse manager (CNM) is the Careerforce Assessor for Dementia unit standards, Foundation Skills level 2 and CORE Competencies. The CNM and FM also participates in the ADHB cluster group meetings two monthly- on falls prevention and pressure injury prevention.

First Aid training- 100% have completed 2013

**Finding Statement**

The annual education programme includes two-three in-service sessions monthly. The service is also proactive around implementing toolbox training talks for staff as a result of incidents, complaints, feedback, observations, benchmarking results and internal audits (also link 1.2.3.6). The following toolbox talks have been provided in 2013 YTD including (but not limited to); a) falls prevention in the hospital (due to increased falls benchmarking),benchmarking results improved in April; b) pressure area care in the hospital in March 13 (due to increased pressure areas benchmarking), as a result these improved in April, c) writing discrepancies in controlled drug register (as a result of an incident), no further incidents were reported; Liverpool Care pathway documentation toolbox as a result of a file review, antipsychotic usage toolbox (link to organisational goal), scabies outbreak and norovirus outbreak. Completed education is captured on electronic spread sheet, easily identifying attendance and capturing those ‘non-attenders.’ Records kept of staff that have read and signed sessions. Personal Best has been rolled out throughout the facility, and has been embraced by the staff. Education is also provided to residents and relatives through the regular newsletters and meetings. The management team also described a new initiative. In 2011 they piloted a numeracy and literacy programme for staff. 10 staff-completed this. Four of their cleaning staff were among those who completed it and who went on to undertake careerforce training. They are now nearing the completion of the foundation skills and Dementia unit standards.

They were one of two Bupa care homes to participate in the University of Auckland’s palliative care research. The purpose of the research is to explore key factors in potentially avoidable admissions from aged residential care. This involved interviewing family members whose relative had died in an aged care facility. The manager advised that researchers will also be providing feedback to the facility as to the perceived experience which might identify gaps as well as identifying positive parts to the process. They are also piloting the CCMS (Collaborative Care Management Solutions). This is an electronic health record and clinical case management plan which provides secure access and up to date resident information directly at the point of care. It enables information to be shared with other health care professionals eg GP Sunset went live with this programme on 10 September. They were one of the first Bupa care homes to implement LCP and complete the training. They achieved 100% in a recent LCP file audit.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. Staff turnover at Sunset is 2.5% compared with an overall average of 25% for Bupa. RN turnover is 50% lower than the 12.5% turnover for Bupa overall. Absenteeism has been reduced by 15%

There is a Facility Manager Mon - Fri and a Clinical Manager (RN) Mon - Fri. There is also part time quality coordinator.

There is good registered nurse cover. The RNs work across all units and stated that helps to get to know residents.

Interviews with 10 relatives and eight residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that they have input into the roster and management were supportive around change when times are busier.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

**STANDARD 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

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

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

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

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. Eight residents (five from the rest home and three from the hospital) and 10 family members (three from the dementia unit, five from the hospital and two from the rest home) 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 Three resident files were reviewed from the dementia unit 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 in the rest home, hospital and dementia unit, with the initial support plan completed within 24 hours of admission. Within three weeks the lifestyle care plan is developed in 10 of 10 files sampled (five from the hospital, three from the dementia unit and three from the rest home).

In 10 of 10 files sampled (five from the hospital, three from the dementia unit and three from the rest home) 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 10 of 10 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.

Eight residents (five from the rest home and three from the hospital) interviewed 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 10 resident files sampled.

D16.2, 3, 4: The 10 of 10 files sampled (five from the hospital, three from the dementia unit and three from the rest home), identified that in all 10 files an assessment was completed within 24 hours and all 10 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. Five of 10 care plans evidenced evaluations completed at least six monthly. The other five residents have not yet been at the service for six months.

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

A range of assessment tools 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. Ten files identified integration of allied health and a team approach is evident in the 10 files. The GP interviewed spoke positively about the service and describes very effective communication processes.

All 10 files have at least an initial physiotherapy assessment with on-going assessments as necessary.

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 dementia:

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

Tracer methodology under 65 years:

    *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

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

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

The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information.

Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse.

Ten of 10 files sampled (five from the hospital, three from the dementia unit and three from the rest home) 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 residents 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:Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed in the three files sampled from the dementia unit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

The sample of files reviewed included;

Hospital - one resident with a current pressure area, one resident with recent unexplained weight loss and one resident who does not speak English.

Dementia - one resident with behaviours that challenge who also has cultural needs, one resident under 65 years old and one resident who has unstable diabetes on insulin.

Rest home - one resident with high needs who has been referred for reassessment, one resident under 65 years with cultural needs and one Maori 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. All nine residents' care plans reviewed on the day of the audit (three hospital , four dementia, two rest home) provide evidence of individualised support and intervention required.

Eight residents (five from the rest home and three from the hospital) and 10 family members (three from the dementia unit, five from the hospital and two from the rest home interviewed confirm care delivery and support by staff is consistent with their expectations. All needs identified in the assessment process were included in the care plans.

There is a long term 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 residents files.

Bupa Sunset has recently taken part in a trial for Bupa of electronic assessments and care plans - CCMS (Collaborative Care Management Solutions). This is an electronic health record and clinical case management plan which provides secure access and up to date resident information directly at the point of care. It enables information to be shared with other health care professionals eg GP Sunset went live with this programme on 10 September. All registered nurses have individual log ins and the programme records the name, time and date of any alterations made. Currently three residents have been trialled with a nursing initial assessment, the dependency rating and the care plan. The assessments automatically populate the care plan which can then be more specifically updated. As caregivers cannot yet access the electronic database all care plans are currently printed and placed in the residents file.

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

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

D16.3f: Ten resident files reviewed identified that family were involved.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Residents' 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 ten residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses stated that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Eight residents (five from the rest home and three from the hospital) and 10 family members (three from the dementia unit, five from the hospital and two from the rest home were complimentary of care received at the facility.

The care plans reviewed were all completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with nine caregivers , 10 families interviewed, three registered nurses, 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.

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 21 residents including 10 with pressure areas (grade 1-2). All residents with pressure areas have appropriate interventions in the care plan including the use of pressure relieving mattresses and cushions, booties and regular turning where appropriate. Two of the residents with pressure areas are under the care of the wound nurse specialist. The organisation benchmarks against pressure areas (link 1.2.3.6) and tool box talks were held to educate staff around pressure area risk management in March and May 2013 to educate staff as the organisation had identified that Bupa Sunset was above the benchmark for pressure areas. Additionally staff education around wound management was provided in April 2013 (10 staff attended) and August 2013 (17 staff attended).

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. One current resident is having input from the DHB wound nurse specialist.

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

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

Care plans are goal oriented and reviewed six monthly. During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

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

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

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

There is one part-time (30 hours per week) qualified diversional therapist and a full-time activities coordinator who are employed as activities officers.

The activities officers provide activities for residents in the dementia unit and for the rest home and hospital level residents. Residents in all areas were observed being actively involved with a variety of activities during the audit. The activities programme diary is developed each month and is displayed in large print on notice boards. Activities are scheduled seven days a week.

 Residents have a complete activities assessment (care plan) completed over the first few weeks following their admission, obtaining a complete history of past and present interests, career, family, culture, likes and dislikes.

D16.5d Ten of ten residents' files reviewed (four hospital, three rest home and three from the dementia unit) identify that the individual activity plan is reviewed when the resident's care plan is reviewed/evaluated.

The activities programme includes networking within the community with social clubs, schools etc. On or soon after admission, a social history is taken ('map of life') and information from this is fed into the lifestyle plan. This plan is reviewed six-monthly as part of the lifestyle care plan review/evaluation. A record is kept regarding each individual resident's activities. There are recreational progress notes in the residents' files that the activity officers complete for each resident every month.

The resident/family/whanau as appropriate is involved in the development of the resident's activity plan. There are a range of activities offered that reflect the residents' needs. Participation is voluntary. The programme is comprehensive and designed for high end and low end cognitive functions and caters to the residents' individual needs. Resident survey results in 2013 indicate 93% of the respondents are satisfied with the activities programme.

Each resident from the dementia unit are provided with one-on-one assistance with activities. Where appropriate, residents with dementia attend the facility's entertainment programme. They are closely supervised by staff (evidenced in interviews with the activities officers and during observations by the auditors). Consideration is taken to provide meaningful activities that cover 24 hours a day, which are conducted by care staff out of normal hours.

D16.5d Ten of ten resident files reviewed identified that the individual activity plan is reviewed during the care plan review.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least a 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 five of 10 care plans sampled (the other five residents have not yet been at the service for six months.). There is at least a monthly review by the medical practitioner.

There are short term care plans to focus on acute and short-term issues. Changes to the long term lifestyle care plan are made as required and at the six monthly review if required. From the sample group of 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 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 dietitians, NASC, hospital specialists, speech language therapists and the physiotherapist.

**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 file (from the rest home) where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

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

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

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

Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the four wings. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses 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 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

There is currently one resident self-administering at Bupa Sunset and this person has a current competency assessment to do so.

 Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Eighteen of 20 medication charts sampled do not document the indication for use for all PRN medications. This is an area requiring improvement. Signing sheets correspond to instructions on the medication chart for 16 of 20 medication charts sampled. This is an area requiring improvement.

The controlled drug register is well kept and aligns with legislative requirements. 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 20% 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 Sunset, the rest home unit has the highest percentage being at 21%. The dementia unit is at 20%. This percentage is 14% above Bupa KPI’s for dementia and the service is actively working to reduce antipsychotic usage.

D16.5.e.i.2; Twenty 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Two of 20 medication charts sampled document the indication for use for all PRN medications. Signing sheets correspond to instructions on the medication chart for 16 of 20 medication charts sampled.

The controlled drug register is well kept and aligns with legislative requirements. 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.

**Finding Statement**

(i) Four of 20 medication charts sampled have regular non-packaged medications prescribed that are not always documented as administered regularly i.e.: inhalers/eye drops. (ii) Eighteen of 20 medication charts sampled have PRN medications charted but the indication for use is not always documented.

**Corrective Action Required:**

(i) Ensure medications are administered as prescribed. (ii) Ensure all PRN medications document the indications for use.

**Timeframe:**

3 months

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

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

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

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

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are on a six weekly cycle, 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 six kitchen staff including two cooks. The main kitchen supplies meals for the four wings of the facility (hospital level, rest home level and the dementia unit].

 All of the kitchen team have received training and been awarded food safety certificates.

The service has a large workable kitchen that contains 1 walk-in pantry, walk-in freezer, walk-in chiller and a domestic refrigerator, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area. Refrigerators are also at each of the four facility wings, which includes the dementia unit. Snacks are provided for residents in the dementia unit 24 hours a day.

Kitchen fridge, food and freezer temperatures are monitored and documented daily. Staff monitor the temperatures daily of the fridges in other areas.

Resident annual satisfaction surveys, which includes food satisfaction are conducted annually. For 2013, 93% of residents are satisfied with the food. This was evidenced further in interviews with eight of eight residents (five rest home and three hospital).

There are a number of internal audits completed including; a) kitchen audit, b) environment kitchen, and ) food service audit.

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

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

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes, evidenced in 10 of 10 residents' files (four rest home level, three hospital level and three from the dementia unit). Nutritional profiles are 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 diabetic diets.

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, and dishwasher are maintained. Weekly temperatures of the bain marie are taken.

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 includes 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 powerpoints 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.

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

D19.2 All kitchen staff have been trained in safe food handling. Training occurs every two to three years.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

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

All chemicals are clearly labelled with manufacturers labels. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. The hazard register identifies hazardous substances and staff interviews confirms their 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 40 hours per week and is also available 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 23 April 2014. .Electrical equipment is checked annually. All medical equipment is calibrated annually by BV Medical and all hoists and electric beds were checked and serviced at this time. All electrical equipment is tested and tagged annually.

The elevator is included in the preventative maintenance programme and is checked annually by an external contractor.

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.

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.

The 2013 resident survey indicates 94% of respondents are satisfied with their 'home-like' environment.

E3.4d, The lounge areas are designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, standing and full hoists, heel protectors, and sensor mats.

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

E3.4.c; There is a safe and secure outside area that is easy to access,.

Since previous audit, there have been some significant improvements as a result of a refurbishment in the corridors and the common lounge and dining areas in our Kowhai and Kauri wings. New lighting was also installed in these areas. A new public corridor has been built in their main dining/activities and the heating and emergency lighting is being upgraded throughout the care home.

Outdoor area landscaped and a garden created for residents and families enjoyment

**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 (one hospital, two combined rest home/hospital and a secure dementia unit). Showers and toilets are located throughout the facility with full ensuites located in the rest home wing.

There are adequate visitor and staff toilet facilities available. Communal toilets and bathrooms have appropriate signage and shower curtains installed. Eight of eight residents interviewed (three hospital and five 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. Nine of nine caregivers from across each area (three rest home, four hospital and two dementia) report that rooms have sufficient rooms to allow cares to take place. Eight of eight residents report that their room is an adequate size to meet their needs.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

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

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

There are two large lounges, one on each level and large dining rooms that are shared by rest home and hospital residents. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. The dementia unit includes a lounge and dining room. 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 eight of eight residents interviewed report they can move around the facility and staff assist them if required.

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 done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed 2 x a year and last done in July 2013 (94%). An environmental hygiene - cleaning audit was last completed in March 2013 (94%). Corrective actions required are followed through the quality/risk management and staff meetings. The satisfaction rate for the laundering service was 86% at the recent satisfaction survey and so to minimise the loss of clothing items they have implemented an electronic labelling system for residents clothing. They purchased a labelling machine and colour coding all sheets and towels.

The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in locked cupboards. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety last took place in August 2013. Fire evacuations are held six monthly. A fire evacuation was last held on 28 August 2013.

There is a comprehensive civil defence manual and emergency procedures manual in place. Civil defence kits are readily accessible on each floor of the facility. They are securely stored in storage cupboards. There is an approved evacuation plan dated 2 Sept 2004

The facility is well prepared for civil emergencies and has emergency lighting and two gas BBQ’s for cooking. A store of emergency water is kept in two storage containers. There are adequate water supplies (three litres of water per person for three days). Emergency food supplies, sufficient for seven days, are kept in the kitchen. Extra blankets are also available.

The manager reports they have a back-up generator that is regularly serviced. This generator can provide emergency power for up to three days.

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 personal protective equipment are kept.

There are two spills kits that are held in storage in the event of a pandemic. Inventory checklists are held in each spills kit. These lists are regularly reviewed.

Ten security CCTV cameras are strategically located inside and outside of the facility. All windows have security locks that are checked by staff each night at 10pm (evidenced in interview with the manager).

The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were overall answered in a timely manner. The manager reports audits of response times to call bells are randomly conducted with evidence to support call bells being answered in a timely manner.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

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

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

The facility has radiant and ceiling heating which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored.

Eight of eight residents interviews (five rest home and three hospital) state the temperature of the facility is 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. Teleconferences are arranged two times a year and include the restraint coordinators at each of the Bupa facilities. The restraint coordinator reports the regional meetings are aimed at reducing restraint use. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint policy includes comprehensive restraint procedures.

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

The service currently has fourteen residents in the hospital assessed as using a restraint. A register for each restraint is completed that includes a three-monthly evaluation.

The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

E4.4a Three of three care plans reviewed in the dementia unit focus on the promotion of quality of life and minimises the need for restrictive practises through de-escalation and the management of challenging behaviours.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

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

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

Only staff who have completed a restraint competency assessment are permitted to apply restraints. All staff restraint competency assessments have been completed at the time of audit with the exception of two staff who are currently on leave.

There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisational level and at a service level. Interview with the restraint coordinator and review of her signed job description identifies her understanding of the role.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau.

Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available which is completed for residents requiring an approved restraint for safety.

The residents' care plans (ten of ten) are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Two restraint files were reviewed (both hospital level). Both residents' files included completed assessments that considered those listed in 2.2.2.1 (a) - (h).

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

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

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

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

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

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

 (f) Maintaining culturally safe practice;

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

 (h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails, lap belts, fall out chairs).

The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plans identifies the specific interventions or strategies to try (as appropriate) before implementing restraint.

Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed monthly during the facility restraint meetings and also as part of the three-monthly restraint reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions are initiated.

The restraint coordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

The resident's file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed in two of two hospital residents with restraint identified observations and monitoring as per their monitoring schedules (bedrails monitored two-hourly and lap belt monitored hourly). Restraint use is reviewed through the three- monthly assessment evaluation, monthly restraint meetings and six-monthly multi-disciplinary meetings and includes family/whanau input.

A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraint.

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

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

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

 (d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of two of two files of residents using restraints identified that evaluations are up-to-date and have reviewed (but not limited to); whether the desired outcome was achieved, whether the restraint was the least restrictive option and the impact of the use of restraint. Restraint is evaluated on a formal basis three-monthly and six monthly by the regional restraint team. Evaluation timeframes are predetermined by risk levels.

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

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

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

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

 (d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. The restraint coordinator from a restraint-free facility presented their findings to the restraint coordinators at the most recent regional meeting.

The organisation and facility are proactive in minimising restraint. The restraint coordinator reports for 2013 restraint usage has dropped from 20 residents using restraint to the current number of 14 residents using restraint. A comprehensive restraint education and training programme is in place which includes restraint competencies.

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

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

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

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

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

The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, Community Lab, the infection control and public health departments at the local DHB. There are two monthly quality/IC meetings and RN/EN 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 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 gastric outbreak was retained to the dementia unit June 13. The service had an outbreak management meeting, Norovirus caselog was maintained and an IC summary/special report completed. There was also a scabies outbreak in the dementia unit June 13 that affected four residents. This was well managed and included a special report. (link 3.5.7).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has attended Bug control training and annually an IC rep from the IC committee attends. 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 June 12 (standard precautions), Infection control (Oct 12), safe food handling (Nov 12), Norovirus (Feb 13). All training is mandated by Bupa and evaluated by staff who attend. Records of the evaluations were sighted.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Infection control data is collated monthly and reported to the Quality and RN/EN meeting. The meetings include the monthly IC report. Infections are documented on the Infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC Programme is linked with the Quality Management Programme. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. There is a number of internal audits completed including (but not limited to) standard precautions (June 97%) - corrective actions were established and evaluated, Food Service (Feb 98.5%), and Environmental Cleanliness (July 92%)- corrective actions were established and evaluated.

**Finding Statement**

The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC stats are discussed at qualified staff meetings and corrective actions are implemented when infections increase. Incident/infection - analysis tool is utilised to assist with identifying trends. In July 13 an increase in respiratory tract infections in the hospital resulted in a QI-CAP being developed including (but not limited); increase temperature monitoring by RNs, increased fluids and supervision. There was no reported RTI in August. A QI-CAP was developed for the dementia unit for two wound infections May 13. Infection stats, trends and education are regularly provided via noticeboards and meetings to staff, residents and relatives. Other toolbox talks provided to staff included (but not limited to); scabies outbreak (10/6), norovirus outbreak (24/6), resp tract infections (11/5), infection control (18/9). A quality initiative has been implemented around UTI prevention: Continence initiative: all residents with incontinence issue use Flex products which has been very cost effective and residents are comfortable. Kitchen staff assisted in providing cranberry juice to the wings on a daily basis. This has been proven successful in their secure wing where there is only 1 UTI YTD, and in the Resthome-three YTD. The service is commended for the management of a norovirus outbreak in the dementia unit in June. A QI-CAP implemented identifies step by step actions taken, progress and evaluation. On-going toolbox talks, education, communication with family and fluid intake records maintained, staff were monitored closely for use of PPE, 4hrly TPR obtained for infected residents. Outbreak management meeting , caselog and IC special report completed. Twelve residents and one staff member infected. As a result of the implemented strategies, the infection was retained in the unit and lasted only one week.

**Corrective Action Required:**

**Timeframe:**