**Bupa Care Services NZ Limited - Liston Heights Rest Home & Hospital**

**Current Status:** **22-Aug-13**

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

**General overview**

Liston Heights is part of the Bupa group. The service is certified to provide hospital (geriatric and medical), dementia and rest home level care. The service can provide care for up to 75 residents. On the day of the audit there were 32 hospital residents and 26 rest home residents and nine residents in the secure dementia unit. Liston Heights has an experienced aged care Facility Manager who is also a registered nurse. She has been the manager at Liston Heights for approximately six years. The manager is also supported by an experienced clinical manager and Bupa regional manager. There are established systems, processes, policies and procedures that are structured to provide appropriate safe quality care for the people in their care. Implementation is supported through the Bupa quality and risk management programme that is established at Liston Heights. The service currently has one HDC complaint that is being investigated and remains open.

The service is commended for achieving a continual improvement rating around quality goals and governance. This audit identified improvements required around informed consent, aspects of care planning, progress reporting/follow up and medication documentation.

**Audit Summary AS AT** **22-Aug-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | 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 Audit22-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit22-Aug-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Continuum of Service Delivery** | Day of Audit22-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit22-Aug-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit22-Aug-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit22-Aug-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **22-Aug-13**

**Consumer Rights**

Liston Heights 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). Liston Heights have a number of staff involved in the programme. Residents and relatives spoke overall positively about care provided at Liston Heights. 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). There is an improvement required around informed consent processes. 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. Improvements are required

**Organisational Management**

Liston Heights has an established quality and risk management system that supports the provision of clinical care and support. A continuous improvement rating has been awarded around implementation quality goals at a service level and organisational level. 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. Liston Heights is benchmarked in three of these (rest home, dementia and hospital). Benchmarking, audit data and corrective actions demonstrate that they continually work to achieving good standards of care and service. 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 input into rostering.

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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.

**Continuum of Service Delivery**

The service has a comprehensive admission policy. 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 implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. There is an improvement required around aspects of care planning documentation and progress reporting.

There are Medication management processes in place. Education and medication competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around aspects of medication charting of 'as required' medication.

The activities programme is facilitated by activities officers. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, van outings are arranged on a regular basis.

All food is cooked on site and residents overall spoke positive about the food service. All residents' nutritional needs are identified, documented and choices available and provided.

**Safe and Appropriate Environment**

The facility is a purpose built facility. All building and plant have been built to comply with legislation. There is a full time maintenance person employed to service the facility and external contractors are employed as necessary. A reactive and preventative maintenance programme is in place that includes monitoring of the environment, equipment and electrical checking. The facility is spacious and each resident has their own bedroom with either ensuites or communal bathrooms. Residents have easy access to landscaped external areas. There is a secure garden and walkway for residents in the dementia unit. Fixtures, fittings and flooring are made of accepted materials for the environment. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites and bathroom areas. There are lounge areas and a dining room in each area. Activities can occur in any of the lounges or in the privacy of their bedrooms if preferred. Furniture is arranged to ensure residents are able to move freely and safely. Housekeeping and laundry are provided on site according to policies and procedures. Regular fire drills are completed. Emergency management and first aid training is included in the education programme. There are civil defence resources in place for the facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms.

**Restraint Minimisation and Safe Practice**

Restraint usage is minimised wherever possible in accordance with the philosophy of the company. There is a restraint minimisation policy that includes comprehensive restraint procedures. There are documented definitions of restraint and enablers that are congruent with the definitions in the standards.

Currently the service has one resident on the register with an enabler in the form of a bedrail. This was well documented in the file reviewed.

There are three residents (bedrails) in the hospital assessed as restraint. There is a restraint and enablers register in use for each resident. Restraint assessments are based on information in the care plan, discussions with residents and on staff observations of residents. Restraint and enabler usage is reviewed for each individual resident at least three monthly and as part of their six monthly multidisciplinary review. Reviews include family/whanau where appropriate. Restraints and enablers are also reviewed at an organisational level and usage is benchmarked between facilities. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

**Infection Prevention and Control**

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

Liston Heights Rest Home & Hospital

Bupa Care Services NZ Limited

Certification audit - Audit Report

Audit Date: 22-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
|  Liston Heights Rest Home & Hospital | 19 Liston Avenue | Hilltop | Taupo |

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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:** 22-Aug-13 **End Date:** 23-Aug-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

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| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RCompN, Health audit cert | 15.00 | 6.00 | 22-Aug-13 to 23-Aug-13 |
| Auditor 1 | XXXXXXX | Medical technologist, MBA lead auditor | 15.00 | 5.00 | 22-Aug-13 to 23-Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 30.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 42.00 |
| **Staff Records Reviewed** | 9 of 65 | **Client Records Reviewed** *(numeric)* | 8 of 67 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 8 |
| **Staff Interviewed** | 15 of 65 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 8 |
| **Consumers Interviewed** | 8 of 67 | **Number of Medication Records Reviewed** | 24 of 67 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 22 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  Liston Heights Rest Home & Hospital | 75 | 67 |       | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.3 Continuum of Service Delivery

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2 Restraint Minimisation and Safe Practice

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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 | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | 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: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 48): CI:0 FA:22 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 | FA | 0 | 8 | 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 | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:1 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 34): CI:1 FA:21 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 10 PA Neg: 0 PA Low: 0 PA Mod: 2 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:19 PA:2 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 |

|  |
| --- |
| 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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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

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

|  |
| --- |
| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 1 **FA:** 46 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 2 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 1 **FA:** 97 **PA:** 3 **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:22-Aug-13 End Date: 23-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.10 | 1.1.10.4 | PALow | **Finding:**Six of eight files reviewed included a flu vaccine (Medical practice flu vaccine consent form) form and a Bupa specific consent in place (two of eight were palliative care/end of life had did not have flu vaccine's given). The Bupa specific consent form had been signed by EPOA or resident at the end of 2012. Of the six medical practice consent/administration forms signed, all six had the signature of the practice nurse administering the flu vaccine, EPOA/resident signature, the batch sticker, but no date to identify what day the flu vaccine was given**Action:**Ensure consent forms are clearly dated to include date of consent and administration date. | 3 months |
| 1.3.6 | 1.3.6.1 | PAModerate | **Finding:**The following documented shortfalls were identified in the six of eight care plans reviewed (noting caregivers interviewed were aware of care required); (i) Dementia files ; a) weight loss management not fully documented in the care plan such as supplements and food & fluid chart. (ii); Rest home files; a) resident returned from two weeks in hospital (old # Nof), care plan not updated/reviewed on return to facility, b) physio progress notes identify a hand wrist paralysis including a splint for management. This was not reflected or updated in the care plan; (iii) hospital files; a) palliative care resident [A] receiving regular pain relief (controlled drugs) were well documented in the progress notes but no evaluation of effectiveness, b) resident with behaviour care plan in place, did not have specific de-escalation techniques to manage the specific behaviours; c) palliative care resident [B] progress notes reviewed identified examples where there was a RN had not written in the progress notes i.e.: caregiver documented 8/8 that 'resident complaining of chest pain, RN checked on resident and settled after morphine'. There was no specific progress notes written by the RN in regards to assessment or care provided. Resident requiring regular qualified nurse input and is on a syringe driver, yet progress notes were not always documented in the afternoon shift. Pain assessment tools not regularly used.**Action:**Ensure care plans include interventions to guide staff, b) ensure pain relief is evaluated for effectiveness, c) ensure RN input for residents with changes in condition and end of life residents is well documented on a regular basis and d) pain assessment tools are utilised on a regular basis | 3 months |
| 1.3.12 | 1.3.12.1 | PAModerate | **Finding:**Three of six medication charts reviewed in the dementia unit and one of eight in the hospital prn medication had no timeframe charted. These included lorazepam, respiridone, loratidine, and diazepam **Action:**Ensure all prn medication charted includes timeframes | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:22-Aug-13 End Date: 23-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |
| --- | --- | --- |
| **Std** | **Criteria** | **Evidence** |
| 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. Liston heights is part of the Bupa midlands region which includes 12 facilities and the Manager's meet six monthly. Facilities Managers forum is provided once a year (first qtr) with an annual organisational managers conference at the end of the year where continuous quality improvement initiatives are celebrated. A two day Clinical Managers forum is also provided annually. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Liston Heights and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. 2013 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'. Liston heights has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa way was 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 2011. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. The B-fit organisational goal is implemented at Liston Heights with a B-fit champion identified to encourage staff participation. The organisation has commenced 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) is tabled at this forum. Three members of the Quality and Risk team are also part of the Bupa Australia/New Zealand Market Unit Clinical Governance Committee which meet bi monthly.Liston heights has identified improvements made as part of goals identified including (but not limited to); a) Residents satisfaction survey improved over the last year from overall satisfaction of 88% in 2012 to 93% in 2013. b) The internal education programme is working well with Registered Nurses taking some responsibility for delivering some sessions, c) Staff also taking responsibility for some audits to relieve work load of Clinical Manager. This also gives staff an insight into the bigger picture and reasons for documentation etc., d) Reduction of restraint is an on-going target at their facility as they are constantly working on the reduction of restraint within the facility every year. This is reflected in the facility quality indicators. The RH and dementia unit remain totally restraint free. |

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

**OUTCOME 1.1 CONSUMER RIGHTS**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

The Code of Rights (the Code) is clearly visible on display at the entrance to the home and on walls throughout the home. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service. This information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and COR competency questionnaires. Interviews with four caregivers showed an understanding of the key principles of the code of rights.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

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

The service notice board includes information on advocacy and advocacy pamphlets are available around the facility. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

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

Interviews with eight relatives (four rest home, four hospital, one dementia) confirmed they are informed of the code of rights and the role of advocates

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The confidentiality and resident privacy policy states the manager is the privacy officer. The policy includes confidentiality, privacy, collection of Information, storage of Information, and access to health information (disclosure). Privacy and communication training was provided April 2013, fourteen staff attended. The personal objects of significance policy outlines the process for the care of personal objects. During the tour of the facility respect for privacy and personal space was demonstrated. Resident files are held in the locked nurses’ office/stations. Interview with support staff could explain ways resident privacy is maintained.

Interviews with eight residents confirmed that privacy is ensured.

The resident satisfaction survey identified that 100% residents stated privacy was either excellent or good.

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

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

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

Five caregivers (one dementia, one rest home, three hospital) could describe examples of giving residents choice including, what time they would like to get up and go to bed, if they would like a shower or not, what they would like to wear and choices about food and activities. There is a question around 'choice' in the resident satisfaction survey, 94% residents stated excellent or good.

A neglect and abuse policy (201) includes definitions and examples of abuse. Staff could describe definitions. Relatives interviewed, eight, said that the care provided is overall very good and staff are very caring. Abuse and neglect training was last delivered in April 2013 ( 25 attended).

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

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

E4.1a The one family member states that their family member was welcomed into the home and personal items and pictures were put up to assist them to orientate to their new environment.

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

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

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

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa’s facilities. The ADHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Liston heights has an attachment to the policy that relates specifically to their area. Local Iwi and contact details of tangata whenua are identified. Special events and occasions are celebrated at the home. This could be described by staff, residents and families interviewed.

Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process. There are currently four residents that identify as Maori at Liston Heights. [A file reviewed of a resident that identified as Maori included cultural consideration/needs and involvement of whanau].

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs**

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

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

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

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

An initial care planning meeting six weeks after admission is carried out, whereby the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. 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. There is 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.

Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services and Liston Heights is benchmarked in hospital, rest home and dementia. Graphs and data is provided to Liston Heights staff in each area and corrective actions completed when trends are evident or areas are above the benchmark, i.e.: CAT 1s were above the benchmark in the dementia unit in Feb 13 and falls in the hospital June 13. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. Bupa has robust quality and risk management systems and these are implemented at Liston Heights supported by a number of meetings held on a regular basis. The service has identified quality improvements including (but not limited to); staff training, facilities improvements and kitchen remodelling.

ARC A2.2 Services are provided at Liston Heights that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring (link improvements identified in 1.2.3). ARC D1.3 all approved service standards are adhered to.

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

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

Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Liston heights- 64.5% of staff have attained bronze, 53.2% silver and 35.5% have achieved gold. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), Liston Heights is part of this. There is a dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. Education is supported for all staff and all caregivers are required to complete foundations level two as part of orientation. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurse’s education day and education session at monthly meeting.

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

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

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

The service has identified the following clinical improvements made since previous audit; Part of the Lakes DHB Vitamin D programme, All residents are now on the person centred care-plan, Close liaison with Taupo Hospice for advice and education for palliative residents, Close liaison with Mental Health for advice & education, Close liaison stoma nurse, Lakes DHB for advice and education, Purchase of “Noodles” as safety tool for use in the residents bed – use as a perimeter ‘guard of sorts’ to help reduce restraint use, More sensor mats purchased so staff are alerted to residents who are at risk of falling as soon as they get out of bed, Sourced GPS equipment from Alzheimer’s for use with residents at risk of wandering off site and Reduction in medication incidents

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

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

The four 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. Incident forms reviewed (42) identified that family were notified.

As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was last completed in April 2013 at Liston heights with a result of 97% satisfactory completion.

Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

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

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

A policy on contact with media is also available.

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

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

**How is achievement of this standard met or not met? Attainment:** 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. Required consent forms (signed by resident EPOA or representative) are evident on eight of eight files. General consent is obtained for (but not limited to) administration of medications, laboratory tests, the use of oxygen and suction in an emergency, medical examination by the GP, care of catheters as required, identification photos and wound photographs, access to clinical records and a named nominated person to provide input into care planning , outings and participation in outings and flu vaccine.

All eight files evidenced a resuscitation plan for medical clinically indicated decisions in the absence of an advance directive made by the competent resident. The resuscitation plan documents there has been discussion with the family. The outcome is confirmed on the form, dated and signed by the GP. There is a GP letter on the residents file that deems the resident incompetent to make a decision on resuscitation.

Discussions with five caregivers ( one dementia, one rest home, three hospital) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Caregivers observed on the day of audit knocked in the resident’s door before entering the room. .

D13.1 there were eight admission agreements sighted and completed on admission

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

The service currently has an HDC complaint in process which involves the flu vaccine consent processes (link 1.1.10.4)

Six of eight files reviewed included a flu vaccine (Medical practice flu vaccine consent form) form and a Bupa specific consent in place (two of eight were palliative care/end of life residents who did not have flu vaccine's given). The Bupa specific consent form had been signed by EPOA or resident at the end of 2012. Of the six medical practice consent/administration forms signed, all six had the signature of the practice nurse administering the flu vaccine, EPOA/resident signature, the batch sticker, but no date to identify what day the flu vaccine was given.

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

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

 Informed consent compliance is also reviewed through internal audit and resident/relative satisfaction.

The service currently has an HDC complaint in process. The complaint alleges inappropriate treatment regarding a resident who was dying and was given the flu vaccination without the recent consent of relative with EPOA (noting consent had been obtained 2x previously, but not this time). As a result the local process for the management of the flu vaccination consent and administration process was reviewed. Suggested amendments to flu vaccination policy was also sent to Bupa policy consult group 1 Aug 13. The HDC complaint remains open.

**Finding Statement**

Six of eight files reviewed included a flu vaccine (Medical practice flu vaccine consent form) form and a Bupa specific consent in place (two of eight were palliative care/end of life had did not have flu vaccine's given). The Bupa specific consent form had been signed by EPOA or resident at the end of 2012. Of the six medical practice consent/administration forms signed, all six had the signature of the practice nurse administering the flu vaccine, EPOA/resident signature, the batch sticker, but no date to identify what day the flu vaccine was given

**Corrective Action Required:**

Ensure consent forms are clearly dated to include date of consent and administration date.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

Advocacy policy (026) states 'All residents will be informed of their right to an advocate' – information on the availability of advocacy services is held within the Admission Agreement. The Health and Disability Advocacy services brochure will be provided by the facility as part of the Admission Information Pack and will be displayed in the facility'. Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with staff described how residents are informed about advocacy and support.

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

D4.1d; discussion with eight family identified that the service provides opportunities for the family/EPOA to be involved in decisions

ARC D4.1e, 1f: the resident file includes 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; : All relatives interviewed (eight) stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit.

There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with eight residents confirmed that the activity staff help them access the community such as go shopping.

D3.1.e discussion with eight staff and eight relatives that they are supported and encouraged to remain involved in the community and external groups such as local churches visit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

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

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

There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with eight residents and eight relatives confirmed they were provided with information on complaints and complaints forms and two described having a concern addressed immediately. Five written complaints were reviewed for Liston heights. All were well documented including investigations and follow up letters. One complaint is still awaiting completion. Two complaints (one still open including one with the HDC ) have arisen following the death of a resident, one of these involved bell time response amongst other issues.

Learning from the complaint was discussed with qualified staff on 14th June in a case review type format.

Both the Care Home and Clinical Manager at Liston Heights reviewed their local process around the management of consent for influenza vaccinations and intend to carry out the following, a) In the future, the home will ensure that a new consent will be obtained from each resident. It is planned that this specific consent would be completed as part of the residents 6 monthly review, b) In the week prior to the planned vaccination date, documented approval from the GP, confirming that the vaccine is clinically indicated for the resident at that time, will also be obtained, d) Copies of this approval will be brought to the facility by the vaccinating nurse (GP’s practice nurse) on the day of vaccination and a record retained at the facility, e) During the vaccination day, the vaccinating nurse and the qualified nurse from the care home will check consent and/or approval has been documented for the resident prior to administration of the vaccination. Should consent not be known, the vaccination will be withheld until such time as this can be confirmed, f) Suggested changes to the Influenza Vaccination policy were forwarded to the policy consult group for their consideration. Reflective practises were completed by the RNs. Additional education was arranged for the 26th and 27th of June regarding palliative care of which four senior caregivers attended. The Manager and CM were also reviewing their processes to ensure all staff understand what should be considered and arranged as appropriate for any resident who may be nearing the end of their life

**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 2013 has set specific quality goals for Liston heights including (but not limited to); staff participation in training and delivering training in the facility and improving communication in the facility.

Bupa Liston Heights provides care for up to 75 residents across three service levels, rest home, hospital and dementia. There are 67 at the time of audit.

The organisation has commenced 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) will also be tabled at this forum. Three members of the Quality and Risk team are also part of the Australia New Zealand Market Unit Clinical Governance Committee which meet bi monthly.

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

Liston Heights has an experienced Facility Manager who is also a registered nurse. She has been the Facility Manager at Liston Heights for approximately six years and has managed other aged care facilities within the region prior to this appointment]. She is supported by an experienced 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.

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

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

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

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

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

Liston heights is part of the Bupa group of facilities and provides care for up to 75. On the day of the audit there were 67 residents (32 rest home, 26 hospital and nine dementia) There are three residents (YPD) under the medical component of their certification. There is also one respite and one resident under a transitional care contract.

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 Liston Heights

There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan to set specific quality goals for 2013 including (but not limited to) improving training within the facility and encouraging staff to deliver training to their colleagues.

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

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. Liston heights is part of the Bupa midlands region which includes 12 facilities and the Manager's meet six monthly. Facilities Managers forum is provided once a year (first qtr) with an annual organisational managers conference at the end of the year where continuous quality improvement initiatives are celebrated. A two day Clinical Managers forum is also provided annually. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Liston Heights and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. 2013 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'. Liston heights has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa way was 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 2011. The new care plan builds on the "Bupa way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. The B-fit organisational goal is implemented at Liston Heights with a B-fit champion identified to encourage staff participation. The organisation has commenced 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) is tabled at this forum. Three members of the Quality and Risk team are also part of the Bupa Australia/New Zealand Market Unit Clinical Governance Committee which meet bi monthly.

Liston heights has identified improvements made as part of goals identified including (but not limited to); a) Residents satisfaction survey improved over the last year from overall satisfaction of 88% in 2012 to 93% in 2013. b) The internal education programme is working well with Registered Nurses taking some responsibility for delivering some sessions, c) Staff also taking responsibility for some audits to relieve work load of Clinical Manager. This also gives staff an insight into the bigger picture and reasons for documentation etc., d) Reduction of restraint is an on-going target at their facility as they are constantly working on the reduction of restraint within the facility every year. This is reflected in the facility quality indicators. The RH and dementia unit remain totally restraint free.

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During a temporary absence, the clinical manager covers the managers role.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

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

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A Bupa policy and procedure review committee (group) meets monthly to discuss the policies identified for the next 2 policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team.

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

Key components of the quality management system link to the Liston heights monthly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the Liston heights units and staff incidents/accidents;

b) The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints;

c) There is an infection control register in which all infections are documented each month. Infection control rates, outbreaks and results of satisfaction surveys are reported to the care services team. The general manager quality and risk is kept informed and is part of the governing body. There is an Infection Control committee at Liston Heights. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the quality, IC and staff meetings.

d) Health and safety committee meetings occur monthly as an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation.

e) The regional restraint approval group meets six monthly and the facility restraint group meets bimonthly. These meetings include a comprehensive review of restraint/enabler use. Restraint internal audit is completed annually.

There is a quality and risk management review process that occurs through monitoring the programme, it 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 staff and management via graphs.

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 Operations Manager which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Operations Managers monthly summaries).

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Liston Heights and document actions that have improved outcomes or efficiencies in the facility. At the time of audit a number of quality improvements were either in place or had been completed: improvements to the facility through redecoration, upgrade to the kitchen and increased use of toolbox talks to keep staff up to date with changes and improvements in service delivery.

The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2013. D19.3 There are implemented risk management and health and safety policies and procedures in place including accident and hazard management.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

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

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

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

The service collects incident and accident data. Category one incidents policy (044) states "The category one incident will be recorded on a standard accident/incident form. The form must provide: a clear account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence. The 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.

Thirteen incidents from the hospital, 20 from the dementia unit and nine from the rest home were reviewed for the month of July 2013. All were completed. Where a family member was notified this was recorded on the form. Staff could describe the process they were to follow when an incident occurred. Eight family members interviewed said they were informed whenever an incident occurred with their family member.

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

Forty two incident forms were reviewed across the service and all demonstrated clinical follow up by a registered nurse/unit coordinator and monitoring (such as neuro obs) having been undertaken when indicated.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet. The home also holds on file copies of the practising certificates for the Doctors and the physiotherapist who work on site.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development nine reviewed files (covering all types of staff) 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 (eight) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the clinical manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (also customised to Bupa - aligned with their policy and procedures). Those working in dementia units may either move straight to dementia unit standards or do core competencies and then continue onto the Dementia unit standards.

There is an annual education schedule that has been implemented. The 2012 and 2013 schedule were sighted. In addition opportunistic education is provided by way of tool box talks - eg. infection control toolbox was provided to clarify documentation requirements. There is an RN training day provided through Bupa that covers clinical aspects of care - eg. wound, care planning etc. 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.

Education liaisons: Hospice, stoma therapy, palliative care, Waiareki Polytech and parkinsons, mental health, wound management

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 for 2013 were sighted in files. Staff interviewed were aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a Nursing 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.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5f There are five caregivers in the dementia unit, three have completed the required dementia standards, one caregiver is in the process of gaining recognition for their qualifications and one is yet to start. This caregiver commenced employment within the last 6 months.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. Staff residents and family interviewed stated there were sufficient staff, although they were often very busy. Rosters were described by staff and then the rosters for August were reviewed. This shows that staff numbers were as described. There is always at least one registered nurse on site at all times, during the morning and afternoon shift there is a registered nurse and/or enrolled nurse in each of the three areas of the home.

**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 and eight family members interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

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

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

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

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

There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

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

In two dementia, three rest home, three hospital files sampled 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 all eight files sampled and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person.

Activity assessments and the activities sections care plans have been completed by an activity therapist.

Five rest home and three hospital residents 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 eight resident files sampled.

D16.2, 3, 4: A registered nurse undertakes the assessments on admission in the hospital, dementia and rest home, with the initial support plan completed within 24 hours of admission. Within three weeks the care plan is developed in all eight files reviewed (two dementia, three rest home, three hospital). There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. Five of eight care plans evidenced evaluations completed at least six monthly (two hosp, one rest home had not been with the service less than six months).

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

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

The care plan summary policy (371) states "the care plan summary is completed by the registered nurse within one week of admission. It is a summarised account of the cares a resident needs and will be used by caregivers to ensure care delivery is in line with the 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. All files reviewed identified integration of allied health and a team approach is evident. There are 12 GPs involved with the service with no identified house GP. One of the GP's interviewed spoke positively about the service and describes very effective communication processes.

Files reviewed included an least an initial physiotherapy assessment with on-going assessments as necessary. The physio is contracted two days a week and a physio assistant 3x weekly.

Tracer Methodology:

Dementia:

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

Rest Home

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

Hospital

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Bupa Liston Heights implement the Bupa assessment booklets and careplan templates for all residents. The assessment booklet includes input from team members and 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. Assessments and support plans are comprehensive and include input from allied health.

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

Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse. Eight of eight resident files sampled (two dementia, three rest home, three hospital) contain assessments including (but not limited to); pressure area risk assessment, falls assessment, pain assessment, skin assessment, MNA, incontinence assessment, behaviour assessment, challenging behaviour and wound assessment (where appropriate). Improvements are identified for one hospital palliative care resident in regards to pain assessments (link CAR 1.3.6.1).

Notes by GP and allied health professionals are evident in residents files, significant events, communication with families and notes as required by registered nurses Improvements are identified for one hospital palliative care resident in regards to RNs progress notes (link CAR 1.3.6.1). Families interviewed (three rest home, one dementia, four hospital) are very supportive of the care provided and express that the needs of their family member are being met.

ARC E4.2; The two dementia resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a The two dementia resident files reviewed included challenging behaviours assessments and management plans

**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; (i) Two dementia residents - a) falls risk/weight loss, b) resident with behaviours that challenge, (ii) Three rest home residents -a) recent hospitalisation for # Nof (in hospital wing), b) new admission following # Nof, c) resident with weight loss and risk of absconding; (iii) Three hospital files - 2x residents palliative care/end of life, b) resident with behaviours that challenge.

Overall service delivery plans (care plans) are comprehensive and demonstrate service integration and input from allied health. The two palliative care residents include input from hospice and palliative care specialist. Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses.

Plans are well described and are reflected in the progress notes. All eight residents' care plans reviewed on the day of the audit (three rest home, three hospital, two dementia) provide evidence of individualised support and intervention required. However refer improvements identified in 1.3.6.1.

Eight residents interviewed and eight families 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.

LTCP include identified interventions for medical needs/ residents risk.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Residents' care plans are completed by the registered nurses in all three areas. Care delivery is recorded by caregivers on each shift (evidenced in all eight residents' progress notes sighted) with input from registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. However improvements are required for progress notes documentation of 'end of life' residents.

Six caregivers ( one dementia, one rest home, three hospital) interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including hoists, wheelchairs, continence supplies, dressing supplies and any miscellaneous items.

Eight residents interviewed and eight families interviewed were overall complimentary of care received at the facility.

Overall the care plans reviewed were completed comprehensively. However, documented shortfalls were identified in regards to aspects of care plans.

Interviews identified that the care being provided is consistent with the needs of residents; this is evidenced by interviews with five caregivers, eight families, four registered nurses, the clinical manager and the facility manager. There is a short-term care plan that is used for acute or short-term changes in health status.

All staff report that there are always adequate continence supplies and dressing supplies. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. On the day of the audit plentiful supplies of these products were sighted. 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. Wound management training Aug 2013. 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.

 D16.3f; All resident files reviewed identified that family were involved.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound care specialist or a continence nurse. Wound folders were reviewed and included assessments and wound management plans.

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

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

Residents' care plans are completed by the registered nurses in all three areas. Care delivery is recorded by caregivers on each shift (evidenced in all eight residents' progress notes sighted) with input from registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Eight residents interviewed and eight families interviewed were overall complimentary of care received at the facility.

**Finding Statement**

The following documented shortfalls were identified in the six of eight care plans reviewed (noting caregivers interviewed were aware of care required); (i) Dementia files ; weight loss management not fully documented in the care plan such as supplements and food & fluid chart. (ii); Rest home files; a) resident returned from two weeks in hospital, care plan not updated/reviewed on return to facility, b) physio progress notes identify a hand wrist paralysis including a splint for management. This was not reflected or updated in the care plan; (iii) hospital files; a) palliative care resident receiving regular pain relief was well documented in the progress notes but no evaluation of effectiveness, b) resident with behaviour care plan in place, did not have specific de-escalation techniques to manage the specific behaviours; c) palliative care resident progress notes reviewed identified examples where a RN had not written in the progress notes i.e.: caregiver documented that 'resident complaining of chest pain, RN checked on resident and settled after morphine'. There was no specific progress notes written by the RN in regards to assessment or care provided. Resident requiring regular qualified nurse input and is on a syringe driver, yet progress notes were not always documented in the afternoon shift. Pain assessment tools not regularly used.

**Corrective Action Required:**

Ensure care plans include interventions to guide staff, b) ensure pain relief is evaluated for effectiveness, c) ensure RN input for residents with changes in condition and end of life residents is well documented on a regular basis and d) pain assessment tools are utilised on a regular basis

**Timeframe:**

3 months

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

There is an activities programme across the seven days. Over the last year the programme has been adjusted and implemented in consultation with residents to increase participation and satisfaction including having staff providing activities seven days per week. The three activity coordinators provide activities across the three areas. Caregivers also provide a number of activities in the dementia unit overseen by the registered nurse and activity coordinator.

 The programme is developed weekly and monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.

Activities are planned to reflect activities of daily living and are age appropriate. Activities are well planned and age appropriate. There are several programmes running that are meaningful and reflect ordinary patterns of life. The residents are able to take trips into the community and maintain their contacts. There is a mobility van that goes out four times weekly. There is a knit and knat group established. Families spoken to were very happy with the programmes available. Residents in the rest home and hospital stated they enjoyed a varied programme.

There is monthly activities meetings.

The service has also built an aviary for dementia unit

D16.5d Eight resident files reviewed identified that the individual activity plan is designed, reviewed and evaluated at the multi-disciplinary meeting.

A comprehensive social history is completed on or soon after admission and information gathered is included in the care plan. The map of life is given to the residents family to complete (dementia unit), and in the hospital and rest home, residents and family are encouraged to complete.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least a one- three monthly review by the medical practitioner. Care plans are evaluated by the registered nurses six monthly or when changes to care occur as sighted in five of eight care plans sampled (two hospital and one rest home is new to the service).

There are short term care plans to focus on acute and short-term issues. Changes to the long term care plan are made as required and at the six monthly review if required (link improvements for one rest home file 1.3.6.1) . From the sample group of residents notes the short term care plans are well used and comprehensive. Examples of STCPs i use included; infections, wounds, challenging behaviours, and unexplained weight loss.

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

**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, hospice, 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.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident’s file. This was sighted in one resident files (from the rest home) where the resident had been transferred to hospital acutely (link 1.3.6.1). All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the three wings. Controlled drugs are stored in a locked safe in the hospital treatment room for the whole facility 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

Medication management was held in April 13 (21 attended). Medication – self administration policy. There are no residents self-administering.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart. 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 28% 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 Liston Heights the dementia unit is currently 72%.

D16.5.e.i.2; 24 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

**Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.**

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

Medications are managed appropriately in line with accepted guidelines. The medications are stored in locked trolleys for each of the three wings. Controlled drugs are stored in a locked safe in the hospital treatment room for the whole facility 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.

**Finding Statement**

Three of six medication charts reviewed in the dementia unit and one of eight in the hospital prn medication had no timeframe charted.

**Corrective Action Required:**

Ensure all prn medication charted includes timeframes

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'. The national menus have been audited and approved by an external dietitian. The service employs six kitchen staff including three cooks. The main kitchen supplies meals for the hospital/rest home and the dementia unit. D19.2 All but one new staff member of the kitchen team at Liston Heights have completed food safety certs.The service has a large workable kitchen that contains 1 walk-in pantry, domestic fridge with snacks for dementia unit, walk in chiller, air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area. The kitchen has been refurbished recently, it was re-commissioned two weeks prior to the audit. Surfaces are easy to keep clean and new appliances have been purchased. Additional kitchenettes are in each area of the home. Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after 6 weeks. There are a number audits completed include; a) kitchen audit, b) Environment kitchen, and c) Food service audit. There is a nutrition - assessment and management policy (347) and a weight management policy (079). The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets and diabetics.There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety. E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

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

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

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

**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 37.5 hours per week and on call. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 1-7-14. Electrical equipment is checked annually. maintenance person interviewed reports that medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. (Records were sighted). The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen/dining areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

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

Caregivers (five), and four RN's interviewed reported that there are good resources available including; standing and full sling hoists, shower chairs, pressure relieving mattresses, transfer belts, slippery sams, pressure relieving cushions, special pressure reliving chairs and specialist crockery and cutlery. Staff reported that if there is a need for equipment identified it is acted upon and obtained by the manager. There is a transportation policy and driver’s licences are checked. The facility has a van available for transportation of residents . Those transporting residents hold a current license and first aid certificate. A van safety audit was completed in May 2013.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

In the rest home, there are a number of rooms with ensuite and kitchenette and regular rooms with ensuite and plus communal showers available. The hospital wing has four communal showers and five communal toilets. The dementia wing has three communal toilets and three communal toilets and one bathroom. There are staff and visitor toilets. Communal toilets and bathrooms have appropriate signage and privacy is ensured

**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 and in the hospital wing it can be demonstrated that wheel chairs, hoists and the like can me manoeuvred around the bed and personal space. There is a lift which is large enough to accommodate a hospital bed Five caregivers from across each area report that rooms have sufficient rooms to allow cares to take place

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

There is a large lounge and large separate dining room that is shared by rest home/hospital residents. There is also two other rest home lounges available. The dementia unit has a spacious lounge and dining room. The lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and 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 six monthly. An environmental hygiene - cleaning audit was last completed in March 2013. The laundry and cleaning room are designated areas and clearly labelled. Improvements have been made since previous audit around Laundry system now in place labelling the residents clothing and also facility Linen to improve laundry services and to decrease loss of resident’s property. There is a keypad lock system on the laundry. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. Resident’s satisfaction survey completed in March 2013 reports 91% satisfaction with the laundry service. Interviews with families/residents identified consistent feedback regarding the excellent and consistent cleanliness of the facility. This was also identified during a tour of the facility by the audit team.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety Feb 2012. Fire evacuations are held six monthly. Fire education and safety in-service was held Feb 13 (42 attended) and Aug (14 attended). First aid training is provided and there are first aid trained staff across 24/7.

There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents’ details. There is an approved evacuation plan dated 25/06/2012.

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

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

Eight residents interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident’s rooms.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

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

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

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has one resident on the register with an enabler in the form of a bedrail. This was well documented in the file reviewed.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. The clinical manager is the restraint coordinator. Job description in place and signed and dated.

Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool and enabler assessment tool available and completed for the residents requiring bedsides/low beds for safety. The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. 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 in the hospital. Both included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly (written evaluation sighted).

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

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

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

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

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

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

 (f) Maintaining culturally safe practice;

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

 (h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

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

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

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

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

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

 (d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

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

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

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

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

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

 (d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

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

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

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

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

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

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

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

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

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

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

**Audit Evidence** **Attainment:** 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 G.P's, the infection control and public health departments at the local DHB. There are monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff.

Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

There have been no recent outbreaks in the facility.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings occur monthly.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control coordinator is responsible for coordinating/providing education and training to staff. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, 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 February, April and March this year. 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 gastrointestinal infections.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

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

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

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

Bupa wide reporting is in place, results of infection monitoring is collated and reported back to the facility. Reports for 2013 were sighted at this assessment.

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

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**