

Bupa Care Services NZ Limited - Cashmere View Rest Home & Hospital

Current Status: 9 January 2014

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

General overview

Cashmere View is part of the Bupa group. The service provides rest home, hospital and psychogeriatric (PG) level care for up to 126 residents

An experienced aged care facility manager (RN) manages the service. A clinical manager, the rest home unit coordinator, team leaders and Bupa regional manager also support her. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Staff turnover remains low.

Family members interviewed stated that they are involved in planning their family members care.

The three shortfalls identified at the previous audit around food service and the security of the new PG unit has been addressed. This surveillance audit identified improvements required around care planning documentation including short-term care plans and medication management.

Audit Summary as at 9 January 2014

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 9 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 9 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 9 January 2014

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 as at 9 January 2014

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 as at 9 January 2014

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 as at 9 January 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Bupa Care Services NZ Limited		
Certificate name:	Bupa Care Services NZ Limited - Cashmere View Rest Home & Hospital		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Cashmere View Rest Home and Hospital (incorporating Ashgrove House)		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services and psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 9 January 2014	End date: 10 January 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			117

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	6
Other Auditors	XXXXX	Total hours on site	16	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	32	Total audit hours off site	11	Total audit hours	43
Number of residents interviewed	8	Number of staff interviewed	14	Number of managers interviewed	4
Number of residents' records reviewed	9	Number of staff records reviewed	6	Total number of managers (headcount)	5
Number of medication records reviewed	32	Total number of staff (headcount)	98	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Tuesday, 18 February 2014

Executive Summary of Audit

General Overview

Cashmere View is part of the Bupa group. The service provides rest home, hospital and psychogeriatric (PG) level care for up to 126 residents. On the day of audit, there were 117 residents (47 rest home residents, 51 hospital residents and 19 residents in the psychogeriatric unit). An experienced aged care facility manager (RN) manages the service. A clinical manager, the rest home unit coordinator, team leaders and Bupa regional manager also support her. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Staff turnover remains low. Family members interviewed stated that they are involved in planning their family members care. The three shortfalls identified at the previous audit around food service and the security of the new PG unit has been addressed. This surveillance audit identified improvements required around care planning documentation including short-term care plans and medication management.

Outcome 1.1: Consumer Rights

Residents and relatives are kept well informed at an organisational and facility level. Relatives interviewed confirmed they were well informed of incidents/accidents and changes of health status. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. 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.

Outcome 1.2: Organisational Management

Cashmere View has an established quality and risk management system that supports the provision of clinical care and support. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Cashmere View is benchmarked in three of these (psychogeriatric, rest home and hospital). 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. Corrective action plans are established when incidents are above the benchmark. 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 the requirements. All caregivers working in the PG unit have completed or are in the process of completing the required dementia standards. The organisational staffing policy aligns with contractual requirements and includes skill mixes. The Bupa wage analysis schedule (WAS) is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide

Outcome 1.3: Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Relatives are involved in planning and evaluating care. Risk assessment

tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents including managing behaviours. Service delivery plans demonstrate service integration and are individualised. Short-term care plans are in use for changes in health status. There is an improvement required around short-term care plan documentation and aspects of care planning interventions. Care plans are evaluated six monthly or more frequently when clinically indicated. There is a planned activities programme across seven days and covers all areas of the facility. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. There are improvements required around medication documentation and management. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Food safety certificates are completed by kitchen staff. These are improvements made since previous audit. There are food service policies and procedures and a link to a dietitian. Weight management is monitored closely by the facility.

Outcome 1.4: Safe and Appropriate Environment

Reactive and preventative maintenance is documented and implemented. The two buildings hold a current warrant of fitness. The service is currently in the process of building a new rest home. The facility is warm with ample space for residents to mobilise. Exterior areas/gardens are well maintained and functional, and provide a safe and secure area for residents.

Outcome 2: Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint. The service has three residents with bedrails on the restraint register (hospital) and nine residents with enablers in the form of bedrail/wheelchair seatbelts and fall-out chair on the enabler register. Enablers are assessed as required for maintaining safety and independence. Enablers are used voluntarily. Training has been provided around restraint, enablers and challenging behaviours.

Outcome 3: Infection Prevention and Control

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections, which have been completed in 2013 as per internal audit schedule. Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	1	1	0	0
Criteria	0	38	0	1	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	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.	PA Moderate	The following shortfalls have been identified in resident files: (1) Rest Home; a) STCPs are in place as required, however interventions are noted in the evaluation sections, b) STCPs have been developed for wounds, however these are sitting in the wound folder and not in the resident file with the LTCP: (2) Psychogeriatric unit; a) one resident's activity assessment documents that he enjoys one on one interactions without	(i)Ensure short-term care plans are current, and evaluated. When a problem becomes long term then this needs to be transferred to long term care plans (ii) Ensure care plans describe current support required to meet assessed needs	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>expanding on what sort of activity he enjoys. His initial care plan (care summary) states that he has a PICC line in situ, it is unclear whether this is still in place. In the same resident's care plan it is documented that following a hospital admission for suspected aspirate pneumonia it was recommended that the resident commence thickened fluids. This has been documented in the evaluation section of the LTCP but has not been updated on the LTCP section itself. There is a short-term care plan for deep vein thrombosis in March 2013, it is unclear whether this is still a health concern. The continence section of the care plan does not include guidelines for staff regarding toileting regimes or other interventions. The resident also has a diagnosis of chronic depression, but this is not documented in his care plan and therefore no interventions are provided;</p> <p>b) resident 2; There is a short term care plan for the resident regarding a</p>		

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>grade one pressure area on his right buttock. The LTCP has not been updated to include a reviewed pressure risk level or pressure prevention interventions (3) Hospital; wound documentation for two pressure areas on L) and R) toes is not separated and therefore difficult to follow; 4) Overall STCPs are well utilised across all three areas for changes in health changes, however these were not fully evaluated or filed as resolved or transferred to the LTCP if remains an issue and therefore difficult to identify if still current or not.</p>		
HDS(C)S.2008	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.	PA Moderate			
HDS(C)S.2008	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.	PA Moderate	<p>The following shortfalls have been identified; (a) Rest home: (i) Six of 16 medication charts have no photo identification. (ii) bi-weekly blood glucose monitoring for a resident on regular insulin has not been documented since 27/ 12/ 13. (iii) An unlabelled handwritten pottle of</p>	Ensure all medication shortfalls as listed above are addressed.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>Trimethoprim and one of Frusemide were found in the drug trolley.</p> <p>(b) Psychogeriatric unit:</p> <p>(i) six of 12 medication charts included antipsychotic medications with no indication for use. (ii) Handwritten notes from the RN are also evident in some resident medication files –e.g. skin care regimes (Note: these were removed on the day of audit). (iii) Three of 12 PRN medication-signing sheets had times the medication was given but not the date of administration. (iv) Eight of 12 medication charts showed no evidence of the general practitioner [GP] having reviewed medications in the last three months. (v) In the drug trolley it was noted that one nitrolingual spray medication had expired and two eye drops were not dated when opened.</p> <p>c) Hospital wing Barrington: (i) One out of 11 medication charts evidenced use of a photocopied chart, which was out of date. The GP had signed the review date on the original chart,</p>		

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				which was underneath. This was not the current copy.		
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	It was stated by the registered nurse and the unit co-ordinator (and sighted) that the medicines are kept by the bedside but not in a locked drawer.	Ensure that residents who self-medicate are supervised and are aware of the need to keep their medicines in a locked drawer	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: 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 1.1.9: Communication (HDS(C)S.2008:1.1.9)

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

Attainment and Risk: FA

Evidence:

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 two team leaders (PG and Rest Home), two registered nurses (hospital) interviewed stated that they record contact with family/whanau on the family/whanau contact record (sited). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for December (11 of 11 hospital, five of six PG unit, 12 of 12 rest home) identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. This was last completed in October 2013 at Cashmere View with a result of 93.3%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b The eight relatives interviewed (four PG, two hospital, two rest home) stated that they are always informed when their family members health status changes.

The Bupa communications manager keeps 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. Newsletters were evident around Cashmere View.

Interpreter's policy and a list of Language Lines and Government Agencies are available. In addition, there is a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available.

D12.1 Non-Subsidised residents/EPOA 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

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

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

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

Attainment and Risk: FA
Evidence: The facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint summary record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to the Quality and Risk team via the facility benchmarking spreadsheet'.

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

ARHSS D13.3g: 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 (seven written, 15 verbal). Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are encouraged and actions and responses are documented. Discussion with eight relatives confirmed they were provided with information on complaints and complaints forms are available at the entrance. One relative described having concerns addressed immediately when brought up with management.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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 (HDS(C)S.2008:1.2.1)

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

Attainment and Risk: FA

Evidence:

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. Cashmere View set specific quality goals for 2013 including (but not limited to); a) to enhance staff wellness and offer incentives for no sickness leave taken in 3 month period, b) To reduce pressure injuries within the hospital by 10%, c) To reduce falls by 10% in the rest home. Progress to meeting those goals were reported monthly.

Cashmere View provides hospital - medical/geriatric, rest home, and psychogeriatric care for up to 126 residents. There were 47 rest home residents in the stand-alone 52-bed rest home, 51 hospital residents across the two hospital units and 19 residents in the 20-bed secure psychogeriatric (PG) unit.

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

The Facility Manager (RN) has many years' experience in management including aged care as well as Acting DON at Christchurch. She has been in the role since August 2012 and is supported by an assistant manager and clinical manager. The clinical manager was on-leave during the audit. There is also three Unit coordinator positions across each area.

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

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

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

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

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

Attainment and Risk: FA
Evidence: Cashmere View continues to have an implemented quality and risk management system. Interviews with staff and review of meeting minutes/quality

action forms/toolbox talks demonstrate a culture of quality improvements and this continues to be maintained since previous audit. Quality and risk performance is reported across the facility meetings, through the communication book, staff noticeboard 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. A Bupa policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure, which are forwarded to the chair of this committee and commonly the Quality and Risk Team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents.

Key components of the quality management system link to the monthly quality committee. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager/assistant manager that break down the data collected across the rest home, psychogeriatric unit, hospital units and staff incidents/accidents. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. There is a monthly IC committee meeting. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee.

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

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

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the Operations Managers region is also provided for the Operations Managers, 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 Cashmere View and document actions that have improved outcomes or efficiencies in the facility i.e.: completing pain charts. The service continues to collect data to support the implementation of corrective action plans e.g.: action plan for increase falls in Psychogeriatric unit August 2013. Responsibilities for corrective actions are identified and improvements noted September 2013.

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

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

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

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.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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

Attainment and Risk: FA
Evidence: D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The completed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff and H&S meeting reflect a discussion of results. Quality improvement corrective action plans were completed when above incidents were above the benchmark including (but not limited to); Rest home-medication errors May 13; PG unit – pressure areas Feb 13. Incident forms reviewed for December 2013 (11 hospital, six PG unit, and 12 rest home) demonstrated clinical assessment and follow up by a RN/clinical manager. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

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

Attainment and Risk: FA
Evidence: Register of registered nurse (RN) and enrolled nurse (EN) practising certificates is maintained, both at facility level and within Bupa. Website links to the

professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).

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

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

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

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

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

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

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

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

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

ARHSS D17.7: The activity therapists working across the PG unit have completed dementia training with the Bupa Dementia Care Advisor and one has completed "Walking in my shoes".

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

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

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The 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. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours. The roster is flexible to allow for the increase of hospital residents or rest home residents.

Staffing is as follows:

Monday-Friday: facility manager and clinical manager.

In the rest home there is a Unit coordinator (RN) five days a week, another RN/EN rostered during the morning shift seven days a week and also during the afternoon shift seven days a week.

In the two hospital units, there is an RN rostered each shift in each of the units.

In the PG unit, there is a registered nurse across 24/7.

Six caregivers interviewed across the three areas reported that staffing was good.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

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

Attainment and Risk: FA

Evidence:

There are admission policies; role of the caregiver, role of the registered nurse, nursing assessment on admission and an admission checklist. In all nine files reviewed (three hospital, three rest home and three psychogeriatric files) the initial admission assessment, care plan summary and long-term care plans were completed and signed off by a registered nurse (RN). Medical assessments are completed on admission by the general practitioner (GP) 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 activities coordinator.

Five residents in the hospital and three in the rest home interviewed stated that they and their family are involved in planning their care plan and at evaluation. Resident files include family contact records, which are completed and up to date in all resident files sampled.

D16.2, 3, 4: A registered nurse (RN) undertakes the assessments on admission in the rest home, hospital and psychogeriatric unit, with the initial support plan completed within 24 hours of admission. In all nine files reviewed [three rest home, three hospital and three psychogeriatric unit], the care plan was completed within three weeks.

There is documented evidence that the care plans are reviewed by a RN and amended when current health status changes. Nine of nine care plans evidenced evaluations completed at least six monthly [three rest home, three hospital and three psychogeriatric unit].

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

A range of assessment tools are 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 (including a diary), d) cultural assessment, e) skin assessment, f) nutritional assessment (MNA), and g) pain assessment.

A care summary is completed on admission and reviewed six monthly. Staff interviewed 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 several GPs involved with the service with no identified house GP. One of the GPs interviewed spoke positively about the service and describes a multi-disciplinary approach to care of the residents. Files reviewed included at least an initial physiotherapy assessment with on-going assessments as necessary. Two registered nurses interviewed are able to identify several residents referred to a dietitian in the last month. One resident in the hospital has been referred to palliative care services and there is evidence of referral to other specialist nursing services such as continence and wound care.

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

Psychogeriatric unit tracer methodology

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

Hospital tracer methodology

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

Rest home tracer methodology

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

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

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.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

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

Attainment and Risk: PA Low

Evidence:

ARHSS D16.1b, D16.2b.

Residents' care plans are completed by registered nurses (RN). Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all nine residents' progress notes). When a resident's health status changes, the RN initiates a review and if required, GP or specialist consultation.

The six caregivers interviewed (two from the rest home, two from the hospital and two from the psychogeriatric unit) stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. RNs on interview confirmed that when equipment was needed that it was provided promptly.

All staff report that there is sufficient stocks of continence products and dressing supplies. On tour of the facility, it was sighted that stock continence and dressing supplies were available for use.

Eight from eight residents (three in the rest home and five in the hospital) were able to verbalise on interview that they feel well cared for. Eight from eight family members (four from the psychogeriatric unit, two from the hospital and two from the rest home) interviewed are also positive about the care that residents receive.

The care being provided is consistent with the needs of residents; this is evidenced by discussions with six caregivers, two registered nurses, two enrolled nurses and the facility manager.

D18.3 and 4: Dressing supplies are available and a treatment room/cupboard is stocked for use in each area. Continence supplies are available and resident files include a urinary continence assessment, bowel management, and continence products identification for day and night use. Specialist continence advice is available as needed and this could be described by the two RNs and two ENs interviewed. In-service continence management and wound management have occurred in the last 12 months. Wound assessment and wound management plans are in place for 10 residents in the hospital, seven in the rest home and five in the psychogeriatric unit. There are corresponding short-term care plans evident for wounds and these are filed in the resident files in the psychogeriatric unit and hospital. Short-term care plans are well used in the facility and in particular the psychogeriatric unit. However, improvements are required to STCP documentation and to storage of wound STCPs in the rest home.

ARC D16.3, RNs and ENs on interview were able to describe how to access specialist wound services/form to use. One out of the seven rest home residents with wounds has specialist nursing services involved in her care (Nurse Maude).

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

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

Attainment and Risk: PA Moderate

Evidence:

ARC 16.2, ARHSS 16.2 All nine resident files reviewed evidenced completed assessments on admission for risk of pressure areas, (Braden scale), falls, continence, nutrition (MNA), challenging behaviours, mobility/transfer at a minimum. Care is then designed by the RN and documented on an initial care summary. There is documented evidence that others in the health care team as well as the resident and/or family have had involvement in the development of the plan. The care being provided is consistent with the needs of residents; this is evidenced by discussions with six caregivers, two registered nurses, two enrolled nurses and the facility manager.

Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence supplies are available and resident files include a urinary continence assessment, bowel management, and continence products identification for day and night use. Specialist continence advice is available as needed and this could be

described by the two RNs and two ENs interviewed. In-service continence management and wound management have occurred in the last 12 months.

Finding:

The following shortfalls have been identified in resident files: (1) Rest Home; a) STCPs are in place as required, however interventions are noted in the evaluation sections, b) STCPs have been developed for wounds, however these are sitting in the wound folder and not in the resident file with the LTCP: (2) Psychogeriatric unit; a) one resident's activity assessment documents that he enjoys one on one interactions without expanding on what sort of activity he enjoys. His initial care plan (care summary) states that he has a PICC line in situ, it is unclear whether this is still in place. In the same resident's care plan it is documented that following a hospital admission it was recommended that the resident commence thickened fluids. This has been documented in the evaluation section of the LTCP but has not been updated on the LTCP section itself.

There is a short-term care plan for deep vein thrombosis in March 2013, it is unclear whether this is still a health concern. The continence section of the care plan does not include guidelines for staff regarding toileting regimes or other interventions. The resident also has a diagnosis of chronic depression, but this is not documented in his care plan and therefore no interventions are provided;

b) There is a short term care plan for the resident regarding a grade one pressure area. The LTCP has not been updated to include a reviewed pressure risk level or pressure prevention interventions (3) Hospital; wound documentation for two pressure areas is not separated and therefore difficult to follow; 4) Overall STCPs are well utilised across all three areas for changes in health changes, however these were not fully evaluated or filed as resolved or transferred to the LTCP if remains an issue and therefore difficult to identify if still current or not.

Corrective Action:

(i) Ensure short-term care plans are current, and evaluated. When a problem becomes long term then this needs to be transferred to long term care plans (ii) Ensure care plans describe current support required to meet assessed needs

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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

Attainment and Risk: FA

Evidence:

The facility employs four activities personnel who work together to provide an activity programme which is developed monthly and is displayed in large print. There is an activities person from 3pm – 8pm across seven days a week. Activities are provided in the hospital Mon – Fri 0830 -1500. Residents are encouraged to keep up community interests and individual pastimes. All residents are assessed on or near admission as to their recreational, cultural and spiritual needs. Family is invited to assist in this development in recognition of their knowledge of the resident.

Activity plans are individualised and take into consideration the residents' abilities and personal preference. There are well documented records of each resident's involvement in group activities.

Cashmere View has a van that is utilised for outings. Access to the community for those immobile /in wheelchairs is available with use of community mobility taxis.

Consideration is taken to provide meaningful activities that can continue over the 24 hours. Four relatives interviewed in the psychogeriatric unit verbalised how difficult it is for their relative to participate but feel that the facility does a good job considering. All residents interviewed in the rest home and hospital also were complimentary about the effort staff put in to the activity programme. One psychogeriatric resident file reviewed documents that the resident enjoys one-on-one activity but does not elaborate on what this activity is. (link 1:3.6.1).

A hospital exercise programme has commenced daily from resident feedback.

ARHSS 16.5g.iii: A comprehensive social history is completed on or soon after admission and information gathered, is included in the lifestyle care plan. Residents are

quick to feedback likes and dislikes to the activity officer. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.
ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

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

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

Attainment and Risk: FA

Evidence:

D16.4a: Care 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.

There are short term care plans to focus on acute and short-term issues (link improvements 1.3.6.1). Changes to the long-term care plan are made as required and at the six monthly review if required (link improvements 1.3.6.1). From the sample group of resident's notes the short-term care plans are well used and comprehensive. Examples of STCPs in use included (but not limited to); infections, wounds, and unexplained weight loss.

ARC: ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

Attainment and Risk: PA Moderate
Evidence: The medications are stored in locked trolleys for each of the three wings. Controlled drugs are stored in a locked safe in the treatment room and only the

registered nurses have access to controlled drugs and two people (one being an RN) must sign controlled drugs out. Regular weekly controlled drug checks are completed.

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 medication charts. The medication folders include a list of specimen signatures and competencies.

Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications. 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 August 2013 with 13 staff attending.

There are currently two residents self-administering in the rest home. While locked drawers are available, these two residents are currently not keeping their medication secure.

The medication charts reviewed included alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name.

Medication audits are completed six monthly. Medication audit completed 69.5% in rest home and 78% in hospital (August 2013). Corrective action plan implemented including toolbox talks for staff.

There is a quality goal at an organisational level to reduce the use of antipsychotics. Advised this is progressing with currently 36% of the facilities total residents being on an antipsychotic medication. This includes PRN medication and they are monitoring their residents to enable them to remove the medication completely. At Bupa Cashmere View, they had 31% antipsychotic use January 2013 and down to 22% October 2013.

D16.5.e.i.2; 16 of 16 rest home, four of 12 PG unit and 11 of 11 hospital medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Shortfalls have been identified around medication management and documentation.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

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.

Attainment and Risk: PA Moderate

Evidence:

There is a separate medication trolley for each unit in the facility. Controlled drugs (CDs) are kept in a locked safe and key held by the senior registered nurse (RN) on duty. Controlled drug registers are well maintained and double signing is evident.

There are up to date staff signatures on file and medication incidents are well followed through and actioned. Medications requiring refrigeration are monitored and temperatures have been documented regularly. The service uses the robotic system in all levels of care; the pharmacy provides these fortnightly.

Finding:

The following shortfalls have been identified; (a) Rest home: (i) Six of 16 medication charts have no photo identification. (ii) bi-weekly blood glucose monitoring for a resident on regular insulin has not been documented since 27/ 12/ 13. (iii) An unlabelled handwritten pottle of Trimethoprim and one of Frusemide were found in the drug trolley.

(b) Psychogeriatric unit: (i) six of 12 medication charts included antipsychotic medications with no indication for use. (ii) Handwritten notes from the RN are also evident in some resident medication files –e.g. skin care regimes (Note: these were removed on the day of audit). (iii) Three of 12 PRN medication-signing sheets had times the

medication was given but not the date of administration. (iv) Eight of 12 medication charts showed no evidence of the general practitioner [GP] having reviewed medications in the last three months. (v) In the drug trolley it was noted that one nitrolingual spray medication had expired and two eye drops were not dated when opened.

c) Hospital wing Barrington: (i) One out of 11 medication charts evidenced use of a photocopied chart, which was out of date. The GP had signed the review date on the original chart, which was underneath. This was not the current copy.

Corrective Action:

Ensure all medication shortfalls as listed above are addressed.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

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

Attainment and Risk: PA Low

Evidence:

There are policies and procedures regarding safe self-administration of medicines. There are two residents in the rest home considered competent to self-medicate. Monitoring of competency occurs three monthly as per the facility policy. It was stated by the RN unit co-ordinator that the medicines are kept by the bedside but not in a locked drawer

Finding:

It was stated by the registered nurse and the unit co-ordinator (and sighted) that the medicines are kept by the bedside but not in a locked drawer.

Corrective Action:

Ensure that residents who self-medicate are supervised and are aware of the need to keep their medicines in a locked drawer

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

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

Attainment and Risk: FA

Evidence:

All resident admitted to the facility are assessed by a registered nurse as to their individual food likes and dislikes. They are also assessed as to their nutritional needs, weighed on admission and a modified nutritional assessment completed (MNA). When a resident is identified as needing specific dietary requirements this is documented on their initial care summary and in the resident progress notes. The kitchen is given copies of these assessments and consequent dietary needs on the day of admission. Colour coded white boards are evident in the kitchen to guide staff in the individual needs of the residents. There is evidence of special diets being provided in the facility such as vegetarian meals and modified diets for those residents at risk of food and fluid aspiration. The cook interviewed described how resident likes/dislikes and special diets were provided to the kitchen and this is an improvement since the previous audit.

Eight from eight residents and eight from eight family members interviewed felt that the meals provided were of a high standard.

Inspection of the kitchen evidenced equipment manuals available for use, routine cleaning schedules in use and regular monitoring of temperatures for fridges and freezers. The temperature of heated food is also routinely checked and documented before being served. The pantry is well stocked and managed with all food on appropriate shelving. Residents and families are surveyed annually regarding the food and its delivery and this was last circulated in 2013. A corrective action plan was established around aspects of the food service following the survey and this was discussed with residents. Resident meetings also discuss the food service and the cook or a kitchen representative often attends to get useful feedback.

Residents and families confirm that there are sufficient staff available at meal times for any resident requiring assistance and snacks are available for residents at all times. All residents are weighed on admission and a food diary is initiated at this time also. When a resident is assessed as needing further intervention a nutritional care plan is developed. There is evidence of a dietitian referral for a resident in the rest home in the last week and two previous referrals in the last month. There is evidence of residents being weighed monthly and for those residents needing closer monitoring evidence of weekly weighs.

D19.2: All kitchen staff have current food safety certificates and this is an improvement on previous audit.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

Attainment and Risk: FA
Evidence: <p>There is a maintenance person who works a total of 40 hours per week and on call. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The two buildings hold a current warrant of fitness. Electrical equipment is checked annually and this was last completed in August 2013. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time, in August 2013.</p> <p>The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are handrails. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>There is a safe external area off the psychogeriatric unit and this is an improvement on previous verification.</p> <p>The service is currently in the process of building a new rest home, which on completion will be attached to the current facility. Currently the rest home unit is a standalone building within the grounds. The building site is well fenced off.</p>

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint policy is in place. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has three residents with bedrails on the restraint register (hospital) and nine residents with enablers in the form of bedrail/wheelchair seatbelts and fall-out chair on the enabler register. Enablers are assessed as required for maintaining safety and independence. Enablers are used voluntarily.

The service has limited restraint use over the last year. Training has been provided around restraint, enablers and challenging behaviours.

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 (HDS(RMSP)S.2008:2.1.1.4)

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.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

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

Attainment and Risk: FA
<p>Evidence:</p> <p>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.</p> <p>Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Quality improvement- corrective action plans have been implemented throughout the year where indicators are above the benchmark including (but not limited to) UTIs in the hospital June and September 2013 and respiratory tract infections September in the rest home. Quality action forms were also established February and July as a result of high UTIs, toolbox talks were provided to staff around preventative actions.</p> <p>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.</p> <p>A scabies outbreak occurred in the rest home (2013), three residents were infected. A special report was completed and toolbox talk for staff provided. This was well managed and resolved.</p>

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>