

# Bupa Care Services NZ Limited - Cedar Manor Rest Home & Hospital

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Current Status: 26 February 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

Cedar Manor is part of the Bupa group. The service provides rest home, hospital and dementia level care for up to 95 residents. On the day of audit, there were 16 residents in the dementia unit, 19 rest home and 49 hospital residents across two units.

Cedar Manor has a facility manager (FM) that has been in the role for the last 10 months. He is a trained physiotherapist and has background a business/management background. He is supported by an experienced clinical manager, unit coordinators across each area and Bupa regional manager.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

Family members and residents interviewed stated that they are involved in planning care and were overall happy with the care provided.

Six of eight shortfalls identified at the previous audit have been addressed. Further improvements continue to be required around care planning interventions/documentation and medication management.

## Audit Summary as at 26 February 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

Indicator	Description	Definition
	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

#### Consumer Rights as at 26 February 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 26 February 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 26 February 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 26 February 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 26 February 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 26 February 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)

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## 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

<b>Legal entity name:</b>	Bupa Care Services NZ Limited
<b>Certificate name:</b>	Bupa Care Services NZ Limited - Cedar Manor Rest Home & Hospital
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Cedar Manor Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care , dementia care
<b>Dates of audit:</b>	<b>Start date:</b> 26 February 2014 <b>End date:</b> 27 February 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	84

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	13.5	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	13.5	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	1

## Sample Totals

Total audit hours on site	27	Total audit hours off site	11	Total audit hours	38
Number of residents interviewed	9	Number of staff interviewed	22	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	4
Number of medication records reviewed	20	Total number of staff (headcount)	108	Number of relatives interviewed	3
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 Wednesday, 19 March 2014

## Executive Summary of Audit

### General Overview

Cedar Manor is part of the Bupa group. The service provides rest home, hospital and dementia level care for up to 95 residents. On the day of audit, there were 16 residents in the dementia unit, 19 rest home and 49 hospital residents across two units.

Cedar Manor has a facility manager (FM) that has been in the role for the last 10 months. He is a trained physiotherapist and has background a business/management background. He is supported by an experienced clinical manager, unit coordinators across each area and Bupa regional manager.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

Family members and residents interviewed stated that they are involved in planning care and were overall happy with the care provided.

Six of eight shortfalls identified at the previous audit have been addressed. Further improvements continue to be required around care planning interventions/documentation 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

Cedar Manor 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. Cedar Manor is benchmarked in three of these (dementia, 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 necessary if incidents are above the benchmark. Improvements have been made since previous audit around corrective action plans.

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 dementia unit have completed or are in the process of completing the required dementia standards and this is an improvement on previous audit.

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**

Service delivery plans demonstrate service integration and are individualised. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. There is evidence of resident and family (where appropriate) involvement in the review of support plans. Previous improvements required around documenting residents and family involvement in care planning, and wound care documentation, have been addressed. However, improvements are still required in relation to documentation of interventions in care plan.

Activities are provided by a diversional therapist and activities assistants. There is evidence of meaningful activities that reflect ordinary patterns of life and residents involvement in the wider community.

There are medication management policies which direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Aspects of medication management shortfalls from the previous audit have been addressed. However, an improvement continues to be required around an expired medication found.

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.

### **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. Refurbishment has been completed to areas of the facility and this is an improvement on previous audit. Further refurbishments are currently in process.

### **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 four residents with bedrails on the restraint register (hospital) and eight residents with enablers in the form of bedrail/wheelchair seatbelts on the 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
<b>Standards</b>	0	15	0	1	2	0	0
<b>Criteria</b>	0	40	0	1	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	32
<b>Criteria</b>	0	0	0	0	0	0	0	58

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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.	PA Low			
HDS(C)S.2008	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.	PA Low	One of four hospital residents currently has a Healthcare NZ wound care nurse involved in management of their wounds. The resident's file did not include any documentation to reflect current management or progress by this wound care nurse. Two of four hospital residents with weight loss had no referral or input from dietitian.	Ensure resident files included integrated notes by all health professionals currently providing care; Ensure dietitian involvement is accessed when required.	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused,	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		integrated, and promote continuity of service delivery.				
HDS(C)S.2008	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.	PA Moderate	The following shortfalls have been identified in resident files (in two of four hospital files, one of one dementia file and one of two rest home files). (i) Dementia – resident with identified behaviours that challenge lacks detail around de-escalation techniques; (ii) Rest Home – resident on respite had incomplete documentation including no initial care plan in place eight days post admission. This was completed on the day of audit; (iii) Hospital – a) resident on special pureed diet, was not reflected in care plan, b) resident with a large burn on abdomen, whose care plan was not updated to reflect management of hot fluids, no pain management identified in LTCP, and no follow up in progress notes to reflect regular monitoring of temperature when temp spiked to 38 degrees.	Ensure care plans reflect current care/interventions to manage assessed needs	90
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	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		guidelines.				
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	(i)Indications for use of medication on the medication chart relate to their generic use and are not all resident specific or missing for prn medication. (ii) There was on glucagon in the hospital fridge that had expired in December 2013. This remains a shortfall since previous audit.	(i)Ensure prescribed prn medication includes the reason for giving to that specific resident; (ii) ensure expired medication is returned to pharmacy in a timely manner	60

## 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; D16.1b.ii; 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 clinical manager 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 (20 across the three areas) reviewed for February 2014 (to date) all identified 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 Oct 2013 at Cedar Manor with a result of 92%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

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

At an organisational level, a residents/relatives association provides a strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the Managing Director, the Director of quality and risk and the consultant geriatrician. Newsletters were in place at Cedar Manor.

Interpreter policy and contact details of interpreters. A list of Language Lines and Government Agencies is available.

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

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'. There is a complaints flowchart.

D13.3h. The complaints procedure is provided to resident/relatives at entry and prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented.

Discussion with six rest home and three hospital residents and three relatives confirmed they were provided with information on complaints and complaints forms. 2013 complaints were reviewed and included six written complaints and three verbal complaints. All were well documented including investigation, follow up letter and resolution.

The service had a MoH inspection 4 April 2013 following a complaint. Of the 11 allegations made by the complainant, the inspection resulted in two partially substantially aspects of the complaint. These were reviewed at this audit and it was identified that the service had in place systems to ensure on-going monitoring of personal hygiene and evaluation of medication changes is occurring.

#### **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.

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

#### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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.

Bupa Cedar Manor provides rest home, hospital and dementia level care for up to 95 residents. There are 16 of 18 residents in the dementia unit and 19 rest home residents and 49 hospital residents across two units. There are two residents on respite contracts in the rest home and one resident in the hospital under an Under 65 contract.

The service is two house GPs that visits two times weekly and a number of residents that have their own GP.

Cedar Manor set specific quality goals for 2013 including (but not limited to); a) to reduce medication errors, b) continue and improve on clinical documentation. Progress reporting quarterly identifies implemented strategies by the service, but does not identify whether the goal is met. The 2014 recently established include; a) improve call bell answering time, b) falls reduction, and c) increase return rate of surveys.

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).

Cedar Manor has a facility manager (FM) that has been in the role for the last 10 months. He is a trained physiotherapist and has background a business/management background. He is also an experienced healthcare auditor in the UK. He was away during the audit at the Bupa manager's forum. The clinical manager was managing the facility in the FM absence; she has 12 years' experience in aged care and has been in the role for the last 10 months. Previously she was in a clinical coordinator role at Cedar Manor. There are job descriptions for both positions that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

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

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.

**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.

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

**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.

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

### 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:**

Cedar Manor continues to have an implemented quality and risk management system. 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. Cedar Manor has implemented a corrective action around ensuring all staff read & sign policies.

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 management coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the rest home, dementia 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 Bupa 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. The service continues to collect data to support the implementation of corrective action plans e.g.: action plan for increase falls across the facility October 2013.

Quality action forms are utilised at Cedar Manor and document actions that have improved outcomes or efficiencies in the facility i.e.: minimising resident clothing loss.

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 an H&S coordinator whom monitors staff accidents and incidents.  
 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.

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Category 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. There were examples where quality improvement corrective action plans were completed when above incidents were above the benchmark including (but not limited to); Rest home- skin tears January 2014. Incident forms reviewed for February 2014 to date (20 across the three areas) 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files reviewed (three caregivers, cook, and activity assistant) included up to date performance appraisals and documentation. 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. Completed orientation booklets are on staff files. Staff interviewed (two registered nurses, two caregivers, unit coordinator and activity assistant) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

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).

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. (Aligns with Bupa policy and procedures).

There is an annual education schedule that is being implemented and covers more than eight hours annually. In addition, opportunistic education is provided by way of toolbox talks. A number of toolbox talks have been completed at Cedar Manor.

There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. dementia, delirium. Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has 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. Currently nine registered nurses have commenced their PDRP, and an enrolled nurse and unit coordinator have completed).

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education provided is an agenda item of the monthly quality meetings.

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

Staff have completed first aid Certificates.

E4.5f There are 12 caregivers that work in the dementia unit. Nine have completed the required dementia standards, one is in the process, and two (new staff members) are yet to start.

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

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

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether over and above hours.</p> <p>Staffing is as follows:          Facility Manager (Physio) Monday-Friday (full time)          Clinical Manager (RN) Monday-Friday (full time)          Unit Coordinator (RN) Monday-Friday (Supernumerary three days and on the floor two days + alternate weekends) across the hospital/rest home units to cover the another UC who is currently on short term maternity leave          There is an RN or EN rostered on morning shift across seven days in the dementia unit. The service is currently advertising for a replacement unit coordinator position in the dementia unit.</p> <p>Interviews with caregivers (across the three areas) three registered nurses and unit coordinator confirmed that staffing levels were sufficient in each of the areas.          Interviews with six hospital and three rest home residents and three relatives confirmed staffing overall was satisfactory.</p>

### 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.

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>The initial assessments and support plans were completed by the registered nurse in six of seven files sampled within three weeks of admission. (four hospital, two rest home, one dementia). One of seven files (rest home respite) did not have the initial assessments or support plan completed eight days after admission (link 1.3.6.1). This documentation was completed and signed off by a registered nurse on day of audit. Improvements to meeting ARC contract timeframes has improved since previous audit.</p> <p>Six of six long term care plans sampled identified that the initial admission assessments, care plan summary and long term care plans were completed by the a registered nurses.</p> <p>D16.2, 3, 4: The six long term files reviewed (four hospital, one rest home, one dementia), evidenced that the care plan is reviewed by a RN and amended when current health changes. All six long-term resident care plans (four hospital, one rest home, one dementia) evidenced evaluations completed at least six monthly.</p> <p>D16.5e: All six long-term resident files reviewed identified that the GP had seen the resident within two working days of admission. It was noted in the five long term resident files the GP had assessed the resident and documented the frequency for review to be between one-three monthly.</p>

In all six long term files a physio assessment, management plans and transfer plans were completed by the physiotherapist. The activities team interviewed confirmed that they complete 'the day in a life of' and activities section of the care plans. Medical assessments were completed within 24 hours of admission by the GP in all six long term care plans sampled. The respite resident file included a letter from her GP, detailing recent events and medication currently being taken.

The residents (six hospital, three rest home) and families (one dementia, one rest home, one hospital) interviewed all stated they felt their care needs were being met.

Hospital tracer:

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

Rest home resident tracer

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

Dementia tracer:

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

#### **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:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>Six caregivers (four rest home/hospital, two dementia) could describe a verbal handover at the end of each duty in all areas that maintains a continuity of service delivery.</p> <p>Seven files (two rest home, four hospital, one dementia) reviewed identified integration of allied health and a team approach. The GP interviewed spoke positively about the service and describes very effective communication processes. Residents with weight loss were noted to be on Ensure, sustagen or fortisip and food/fluid monitoring charts were in use.</p> <p>Resident files have at least an initial physiotherapy assessment with on-going assessments as necessary. There is a physio two days a week and a physio assistant across five days.</p> <p>A number of systems were noted which promote continuity of care and a team approach. Changes in resident conditions are documented at the end of each shift in a facility manager report and in the progress notes. Care staff have ready access to the progress notes. Staff were observed accessing client files and referring to the care plan summary in the two hospital wings during the audit.</p> <p>A team approach was is evident in five of five long term resident files sampled. Referrals to a plastic surgeon, speech and language therapist, podiatrist and mental health service for the older person were seen. The outcomes of these referrals were incorporated in the care plans.</p> <p>The general practitioner spoken to commented that there was good communication between the care staff, families, allied health and the medical service. The general practitioner felt the service operated in a collaborative manner.</p> <p>One of four hospital resident files sampled is having a wound managed by an external provider. No wound management documentation is kept by the external provider in the resident notes.</p>
<p><b>Finding:</b></p> <p>One of four hospital residents currently has a Healthcare NZ wound care nurse involved in management of their wounds. The resident's file did not include any documentation to reflect current management or progress by this wound care nurse. Two of four hospital residents with weight loss had no referral or input from dietitian.</p>

**Corrective Action:**

Ensure resident files included integrated notes by all health professionals currently providing care; Ensure dietitian involvement is accessed when required.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Assessments completed on admission are comprehensive. Six of seven 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 (One file is a respite resident). Care is then designed by the RN and documented on an initial care summary. Plans overall are well described and are reflected in the progress notes. STCPs are in use for acute changes in health status. The previous report identified a shortfall around interventions and this finding remains.

**Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Assessments completed on admission are comprehensive. Six of seven 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 (One file is a respite resident). Care is then designed by the RN and documented on an initial care summary. Plans overall are well described and are reflected in the progress notes. STCPs are in use for acute changes in health status. The previous report identified a shortfall around interventions and this finding remains.

**Finding:**

The following shortfalls have been identified in resident files (in two of four hospital files, one of one dementia file and one of two rest home files). (i) Dementia – resident with identified behaviours that challenge lacks detail around de-escalation techniques; (ii) Rest Home – resident on respite had incomplete documentation including no initial care plan in place eight days post admission. This was completed on the day of audit; (iii) Hospital – a) resident on special pureed diet, was not reflected in care plan, b) resident with a large burn on abdomen, whose care plan was not updated to reflect management of hot fluids, no pain management identified in LTCP, and no follow up in progress notes to reflect regular monitoring of temperature when temp spiked to 38 degrees.

**Corrective Action:**

Ensure care plans reflect current care/interventions to manage assessed needs

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **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:** FA

**Evidence:**

The care being provided is consistent with the needs of the resident as evidenced through interview with residents, families and staff.

Residents' care plans are completed by registered nurses or an enrolled nurse and checked and countersigned by a registered nurse. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all seven residents' progress notes). When a resident's health status changes, the registered nurse initiates a review and if required arranges general practitioner or specialist consultation. The families interviewed confirmed they are informed if there has been a change in health status.

The six caregivers interviewed (two dementia , four rest home/ hospital ) stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Registered nurses spoken to confirm that when equipment is needed it is provided promptly. Staff spoken to all report access to educations for specialist care services. Staff report that there is sufficient stocks of continence products. On tour of the facility, it was sighted that stock continence and dressing supplies were available for use. On occasions issues arise with the supply of adequate dressing products and emergency supplies are then sourced externally.

Seven of seven residents (three in the rest home and four in the hospital) were able to verbalise on interview that they feel well cared for. Three family members (one Dementia, one rest home, one hospital) interviewed are very positive about the care that residents receive.

There is an improvement noted since previous audit in relation to wound care documentation. Wound assessment and wound management plans are in place for 14 residents in the Craig wing (rest home/hospital), 16 residents in Central (rest home/hospital) and four in Bakker (dementia unit). There are corresponding short-term care plans evident for wounds and these are filed in the resident files. Of this number 19 were attributed to just 7 residents There are wound management plans in place for three pressure areas (all hospital).

During the tour of facility it was noted that all staff treated residents with respect and dignity, which was confirmed by the residents and families.

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is one trained diversional therapist and two activities assistants that provide activities across each area. The diversional therapist has recently resigned and an activities co-ordinator has been employed to replace her. Collectively the activities team are employed for 88 hours a week for hospital, rest home and dementia activities. There are several programmes running that are meaningful and reflect ordinary patterns of life. There is evidence of the wider community involvement with regular outings, church services and school groups visiting. The programme is developed monthly and displayed in large print. Residents are given opportunity to feedback on the programme through the newly introduced compliments and suggestions booklet. Residents spoken to report satisfaction with the activities programme.</p> <p>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. and information from this is fed into the care plan.</p> <p>A record is kept of individual residents activities. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan.</p> <p>D16.5d The six long term resident files reviewed identified that the individual activity plan is evaluated and reviewed as part of the care plan review.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> 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 1.3.5.2). Changes to the long-term care plan are made as required and at the six monthly review if required). From the sample group of resident's notes the short-term care plans are well used and comprehensive. Examples of STCPs in use included (but not limited to); infections, wounds, behaviours that challenge and unexplained weight loss.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>The two weekly robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication treatment rooms/cupboards were checked across the three areas. Previous audit findings have been addressed by the service with the exception of an expired Glucagon in one of the hospital fridges.</p> <p>Two medication rounds were observed. The Registered nurse administering the medication observed the correct procedures and checks. The medications are stored in locked trolleys in hospital and rest home and dementia areas. Controlled drugs are stored in a locked safe in the hospital treatment room and only the registered or enrolled nurses have access to controlled drugs and two people (one being an RN) must sign controlled drugs out. The controlled drug register is well kept and aligns with legislative requirements. Weekly CD checks are completed by the registered nurse.</p> <p>There is currently one resident self-administering in the rest home area. The resident has been assessed as being safe to self-administer medication and it is noted in the care plan that the resident is self-medicating. The registered nurse checks that the medication has been taken as charted and notes this on the signing sheet. The</p>

medication is secured in a locked cupboard.

D19.2 d Medication is managed safely and appropriately in line with accepted guidelines. Twenty medication charts were sampled. (Eight hospital, eight rest home, four dementia). All medication charts reviewed identified that the GP had seen the resident and reviewed the medication chart 3 monthly. Medication profiles are computer generated and are legible, up to date and reviewed at least three monthly by the GP, eye drops in use and dated and this is an improvement on previous audit. The medication chart has alert stickers for crushed, allergies, and duplicate name. Medication charts have photo ID's. Residents/relatives interviewed stated they are kept informed of any changes to medications.

**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.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The two weekly robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication treatment rooms/cupboards were checked across the three areas. Staff sign for the administration of medications on medication sheets held with the medicines. Signing sheets correspond to instructions on the medication chart and all charts sampled evidenced that medication had been signed for. A list of specimen signatures and competencies are in each medication area.
<b>Finding:</b> (i)Indications for use of medication on the medication chart relate to their generic use and are not all resident specific or missing for prn medication. (ii) There was on glucagon in the hospital fridge that had expired in December 2013. This remains a shortfall since previous audit.
<b>Corrective Action:</b> (i)Ensure prescribed prn medication includes the reason for giving to that specific resident; (ii) ensure expired medication is returned to pharmacy in a timely manner
<b>Timeframe (days):</b> 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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:** 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 1.3.12.6 (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:**

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

All kitchen staff at Cedar Manor have completed food safety certs.

The service has a large workable kitchen that contains one walk-in pantry, freezer, a domestic fridge with snacks for dementia unit, walk in chiller, air steam oven, bain maries, microwave, commercial oven and hot plates. There is a preparation area and receiving area.

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.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number audits completed include; a) environment kitchen - 86% with completed action plan, b) food storage audit – 88% with completed action plan and re-audit 100%, and c) food service audit – 90.6%.

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 and gluten free.

Food is transported to the hospital/rest home in a bain marie and to the dementia unit in a hot box.

E3.3f: There is evidence that additional nutritious snacks available over 24 hours for all residents, dementia residents have access to snacks between meals. Residents weight charts identified weight stability and where weight loss is identified residents are placed on a weekly weight chart. Supplements are available and described by caregivers. STCPs were in place for residents with unexplained weight loss as evident in two of four hospital files reviewed (link 1.3.3.4).

Advised that residents can have breakfast in their room. MNA assessments are completed on admission and six monthly and identify those residents at risk of malnutrition.

A satisfaction survey in which meals satisfaction is completed annually (last May 2013). This was also re-issued in Sept 2013 Food service - 62%, corrective actions were implemented and shared with resident/relatives at meetings (sited).

Overall interviews with six hospital and three rest home residents confirmed satisfaction with the meals provided.

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

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

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

## 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:**

There is a maintenance person who works full time 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 28 February 2014 (advised that has been reviewed since the draft report). Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and all hoists and electric beds were checked and serviced at this time. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

The previous report identified damaged skirting boards, door frames and wallpaper in Central Wing One. Refurbishment has occurred in these areas.

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.

ARC D15.3: There is adequate equipment available across the facility as confirmed through interviews with staff.

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

E3.4.c: There is a safe and secure outside area that is easy to access off the dementia unit. The outside area for residents in the dementia unit is well designed and appropriate for residents who like to walk about.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

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

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**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 four residents with bedrails on the restraint register (hospital) and eight residents with enablers in the form of bedrail/wheelchair seatbelts on the register. Enablers are assessed as required for maintaining safety and independence, enablers are used voluntarily.

The service has reduced 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):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

### Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

Care plans reviewed of two hospital residents with restraint bedrails identified observations and monitoring. Restraint monitoring forms reviewed had been regularly completed and this is an improvement on previous audit. Restraint/enabler use is reviewed through the monthly assessment evaluation, three monthly restraint meetings and six multi dip meeting and includes family/whanau input

### Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

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.

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

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### 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

**Evidence:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files, infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

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

**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.

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