Bupa Care Services NZ Limited - Tararu Rest Home & Hospital

Current Status: 25 August 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

Bupa Tararu provides care for up to 62 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 61 residents, including 27 hospital residents and 34 rest home residents.

Bupa policy, systems and processes are well established with support by the operations manager and Bupa quality and risk team. Residents and relatives interviewed spoke positively about the care and support provided at Tararu. Tararu has an experienced facility manager (registered nurse) that has been in the role for fifteen months and has a background of working for Bupa in aged care for seventeen years. The manager is supported by a clinical manager (registered nurse) who has been in the role for five and a half years.

The service has addressed the shortfalls identified at the previous audit around care planning interventions and medications. Further improvements are required around documentation of corrective action plans at the quality and staff meetings and wound care documentation.

Audit Summary as at 25 August 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

Indicator	Description	Definition
	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 25 August 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.

Organisational Management as at 25 August 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.		Some standards applicable to this service partially attained and of low risk.

Continuum of Service Delivery as at 25 August 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 low risk.

Safe and Appropriate Environment as at 25 August 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.

Restraint Minimisation and Safe Practice as at 25 August 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.

Infection Prevention and Control as at 25 August 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.2)

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 - Tararu Rest Home & Hospital

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Tararu Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 25 August 2014 **End date:** 26 August 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:	

Audit Team

Lead Auditor	XXXXXX	**Hours on site**	14	**Hours off site**	
Other Auditors		**Total hours on site**		**Total hours off site**	
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXX			**Hours**	2

Sample Totals

Total audit hours on site	14	Total audit hours off site	8	Total audit hours	22

Number of residents interviewed		Number of staff interviewed		Number of managers interviewed	2
Number of residents' records reviewed		Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed		Total number of staff (headcount)		Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXX, 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 Thursday, 25 September 2014

Executive Summary of Audit

General Overview

Bupa Tararu provides care for up to 62 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 61 residents; including 27 hospital residents and 34 rest home residents. Bupa policy, systems and processes are well established with support by the operations manager and Bupa quality and risk team. Residents and relatives interviewed spoke positively about the care and support provided at Tararu. Tararu has an experienced facility manager (registered nurse) that has been in the role for fifteen months and has a background of working for Bupa in aged care for seventeen years. The manager is supported by a clinical manager (registered nurse) who has been in the role for five and a half years.
The service has addressed the shortfalls identified at the previous audit around care planning interventions and medications. Further improvements are required around, documentation of corrective action plans at the quality and staff meetings and wound care documentation.

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

Tararu has established Bupa quality and risk management systems. Quality and risk performance is reported across the facility meetings, and also to the organisation's management. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Tararu is benchmarked in two of these (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. An improvement is required around documentation of corrective actions plans at the quality and staff meetings.
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.
The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Outcome 1.3: Continuum of Service Delivery

The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and are reviewed at least six monthly. Resident files include notes by the general practitioner, nurse practitioner and allied health professionals. There are improvements required around documentation on wound care charts.
Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.
The activities programme is facilitated by an activities coordinator and residents and families report satisfaction with the activities programme. The programme includes significant community engagement. The cook cooks all food on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and a dietitian has reviewed the Bupa menu plans.

Outcome 1.4: Safe and Appropriate Environment

The building holds a current warrant of fitness, which expires on 18 May 2015.

Outcome 2: Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers. There are clear guidelines in the 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 and is included in the policy. Currently the service has ten residents on the register with an enabler in the form of bedrails. Five files reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. The service currently has no residents on restraint and has been restraint free for one year.

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

Outcome 3: Infection Prevention and Control

The infection control (IC) programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	2	0	0	0
Criteria	0	39	0	2	0	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	32
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 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality meetings for February, March, April, and May 2014 do not show documented evidence that corrective action plans are discussed and that corrective actions identified are followed through to improve on clinical indicators.	Ensure that meeting minutes document corrective action identified and actions/improvement made towards the corrective actions.	90
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	PA Low	One resident (rest home) has a new wound documented on an old assessment and treatment form	Ensure that there is a new wound assessment and treatment plan completed for	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		consumers' assessed needs, and desired outcomes.		and three residents (hospital) do not have all the documentation completed on the assessment form.	each wound and that all documentation is completed on the wound assessment form	

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 clinical manager and two registered nurses interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for July 2014 identified that 14 of 14 (eight rest home and six hospital) incident forms demonstrated that family were notified or that family only wanted to be notified of serious incidents.
D16.4b: All six (one rest home, five hospital) relatives interviewed stated that they are always informed when their family members health status changes.

There is a Bupa residents/relatives association that 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 chief executive officer, the general manager quality and risk and the consultant geriatrician. There is also a Bupa NZ communications manager. This person's role is to keep people informed and engaged about Bupa NZ's strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.

Interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and Government Agencies is available. In addition, there is a number of staff who is able to assist with interpreting for care delivery. A policy on contact with media is also available.
D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D11.3 The information pack is available in large print and advised that this can be read to residents

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

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

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 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 also prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented.
Discussion with four rest home and three hospital residents and six relatives confirmed they were provided with information on complaints and complaints forms.
Complaints for 2014 were reviewed which included one written complaint in May, one verbal complaint in June and one verbal complaint in July. Complaints in 2013 included four written complaints and four verbal complaints. All complaints were well documented including investigation, follow up letter and resolution in a timely fashion.

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.
Tararu has set specific quality goals for 2014 including (but not limited to); a) to increase resident satisfaction of meaningful activity from 92% to 95% and b) to increase residents satisfaction of well trained staff from 91% to 93% and maintain staff global survey of “I have the training I need to do my job well”. Strategies are in place for each goal and progress is reported quarterly with the May 2014 progress report documented.

Bupa quality and risk systems and processes are well-established with support by the operations manager and Bupa quality and risk team.

Bupa Tararu provides care for up to 62 residents across two service levels (rest home and hospital - geriatric/medical). Occupancy on the day of audit was 61 residents; including 27 hospital residents and 34 rest home residents. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager. Tararu is part of the midlands Bupa region which includes 11 facilities. The managers in the region meet two monthly and a forum is held every six months with all the Bupa managers. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Tararu and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on-going progress to meeting their goals. A forum is held every six months (with national conference including all the Bupa managers).
The organisation has a Clinical Governance group. The committee meets two monthly. The committee reviews the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Feedback is provided to managers at forums and also to staff through newsletters (sighted at Tararu). 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).

Bupa 2020 has been introduced at Tararu and this is a vision of where Bupa wants to be in the future for “our customers, our people and our communities”. Bupa 2020 is goals that will “help us to deliver our purpose of, longer, healthier and happier lives”. Bupa goals include, people love working at Bupa, extraordinary business performance and a healthcare partner to millions more people around the world. Strategies are in place to reach the goals including, by doing our personal best, by living the Bupa way and that our people are most important to us in reaching our goals.

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. Tararu benchmarks against rest home and hospital.

Tararu has an experienced facility manager (registered nurse) that has been in the role since May 2013. The facility manager previously held a relief manager role for Bupa and prior to that was a facility manager in the United Kingdom. She has worked in Bupa aged care management for 17 years. The manager is supported by a clinical manager (registered nurse) who has been in the position for five and a half years and acts as the manager when the manager is away. 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 (February 2014).

ARC, D17.3di (rest home and hospital), the manager and clinical manager has maintained at least eight hours annually of professional development activities related to managing a hospital including first aid training in April 2014, code of conduct NZNC April 2014). InterRAI training and attending Bupa managers conferences.

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): *(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.

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 1.2.3: 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: PA Low

Evidence:

Tararu has established Bupa quality and risk management systems. Quality and risk performance is reported across the facility meetings, 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. Bupa policies and procedures have been implemented throughout the year. A number of core clinical practices also have education packages for staff, which are based on their policies. These are implemented at Tararu. 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. There are terms of reference for the review committee and they follow a monthly policy review schedule.
Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy (as sighted for a new policy regarding neurological observations implemented May 2014). The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the monthly and two monthly staff meetings at Tararu and the monthly quality committee. Weekly reports by facility manager to Bupa operations manager and month 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/hospital and staff incidents/accidents. The service has linked the complaints process with its quality management system. Weekly and monthly manager reports include complaints. Infection control is included in the quality 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 is an agenda item at the quality committee.

Staff meetings at Tararu include monthly quality, registered and enrolled nurses, hospital staff, and two monthly, health and safety, rest home staff, household staff and kitchen staff. All meeting minutes (with identified quality data collected and trends) and corrective action plans are displayed in the staff room and there is a communication book for registered nurse where notes on corrective actions are documented. However improvements are required around ensuring meeting minutes (including quality meetings and registered nurse meetings) include documented discussion of corrective actions identified and are followed through to improve on clinical indicators. Quality meetings for February, March, April, and May do not show documented evidence that corrective action plans are discussed (quality meeting minutes for August show documented evidence that corrective action plans are discussed). The service collects data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. The service has implemented a number of corrective actions. Action plans developed following audits include but not limited to: multi-disciplinary meetings (95%) and weight management (91.4%) February 2014, nursing hygiene rest home (93.3%) March 2014, and clinical files (90.8%) April 2014. A resident satisfaction survey was last completed October 2013 with 90% overall satisfaction and including 91% for well trained staff (part of Tararu quality goals 2014) and 92% for meaningful activities (part of Tararu quality goals 2014). The service has implemented the following towards the meaningful activities strategies and goal: a new bookcase for one of the lounges, a fish tanks has been purchased, the TV in the hospital lounge has been moved to another wall to open up the lounge and allow residents to view

outside and be more user friendly, ukuleles have been purchased, a family member is teaching residents how to play, and activities in the hospital have been extended to include weekends.

The service also implements 'quality indicator - corrective action plans' (QI-CAP) where incidents/infections are above the benchmark.
D19.3: There is an 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.

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 1.2.3.3 (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): *(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.

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

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: PA Low

Evidence:

All meeting minutes (with identified quality data collected and trends) and corrective action plans are displayed in the staff room and there is a communication book for registered nurse where notes on corrective actions are documented. The service collects data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. The service has implemented a number of corrective actions.

Finding:

Quality meetings for February, March, April, and May 2014 do not show documented evidence that corrective action plans are discussed and that corrective actions identified are followed through to improve on clinical indicators.

Corrective Action:

Ensure that meeting minutes document corrective action identified and actions/improvement made towards the corrective actions.

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

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

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

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

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 category one incidents. The competed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)".
Incident forms reviewed for July 2014 (14 forms) identified clinical follow up by a registered nurse/clinical manager and monitoring (such as neurological observations) having been undertaken when indicated. Opportunities for improvement are documented on the incident form by clinical manager.

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. Quality indicator- corrective action plans are established when they were above the benchmark.
Discussions with the facility manager and clinical manager confirm 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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 and enrolled nurses practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet.
The Bupa orientation programme provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, registered nurse four weeks), during this period, they do not carry a clinical load.
Staff interviewed (four caregivers, two registered nurse) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.
There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files were requested for viewing (clinical manager, registered nurse, caregiver, activity coordinator, cook and housekeeper). Appraisals, compulsory training sessions and staff competencies are up to date. One caregiver file reviewed has been at the service less than 12 months and therefore the appraisal is not due.

Interviews with the 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. Education provided in 2014 included but not limited to; February, continence assessment (13 attended) and wound assessment (15 attended), March, pain management (16 attended) and communication (27 attended), April, first aid (13 attended), May, fire safety and evacuation (32 attended), June, abuse and neglect (29 attended), April 2013, code of rights and advocacy (19 attended) and open disclosure and privacy (27 attended). In addition, opportunistic education is provided by way of toolbox talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care. Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place.
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 are aware of the requirement to complete competency training.
D17.7d: registered nurse competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, restraint, wound management, and subcutaneous fluids.

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.

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. A report is provided fortnightly from head office that includes hours and whether hours are over and above. There is a registered nurse across 24/7. The facility manager and clinical manager are both registered nurses. Interviews with four caregivers that work across the facility identified that staffing levels were overall good.

Interviews with seven residents and six relatives stated overall that staffing was adequate.

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:

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. This was included for all six files sampled (three from the rest home and three from the hospital). Within three weeks, the care plan is developed in six of six files sampled.

D16.2, 3, 4: In six of six files sampled the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission by the general practitioner (GP) in six files sampled and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person in three of the six files sampled (one rest home and two hospital residents have been at the service less than six months).
Seven residents interviewed (three hospital and four rest home) stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family contact records, which were completed and up to date in the six resident files sampled.
D16.5e: Five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly in five of six file sampled.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Six files identified integration of allied health and a team approach is evident in the six files. The GP interviewed spoke positively about the service and describes very effective communication processes. The GP interviewed reports that she is contacted promptly of any change to a resident's condition and since April 2014 has implemented two scheduled visits each week. There is also a nurse practitioner who works alongside the GP and since April 2014 visits the service twice weekly (different days to the GP) and reports any concerns and follow-up to the GP. Both the GP and nurse practitioner interviewed spoke highly of the new service and improved medical care for residents.
In six of six files, an activities coordinator has completed activity assessments and the activities sections of the care plans.

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

Tracer methodology rest home: *XXXXXX This information has been deleted as it is specific to the health care of a resident.*

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:

Finding:

Corrective Action:

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

Criterion 1.3.3.4 (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): *(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: FA

Evidence:

The previous audit identified that two long term care plans did not have interventions updated to reflect changes in health status. All six resident care plans sampled for this audit had all interventions documented to reflect health status. These previous shortfalls have now been addressed. The previous audit identified that a respite resident assessment was not updated from a previous assessment. There was no respite resident at the service during this audit.

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: FA

Evidence:

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Finding:

Corrective Action:

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

Standard 1.3.6: 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:

The registered nurses complete residents' care plans. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all six residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The four caregivers and two registered nurses interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Seven residents interviewed (three hospital and four rest home) and six families interviewed (five from the hospital and one from the rest home) were complimentary of care received at the facility.
The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers, and six families interviewed, two registered nurses, the facility manager and the clinical manager.
D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.
Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.
Continence management in-services and wound management in-service have been provided in February 2014.
Wound assessment and wound management plans are in place for four residents (rest home) with six wounds and nine residents (hospital) with 11 wounds. This includes one pressure area (hospital). All have an assessment, management plan and evidence of timely review. However one resident (rest home) has a new wound documented on an old form and three residents (hospital) do not have all the documentation completed on the assessment form. This is an area requiring improvement. The clinical manager and registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.
The facility has registered nurse cover 24/7 and has an 'in service' education programme.
Records of all health practitioners practicing certificates are kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse.
During the tour of facility, it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

Registered nurses are scheduled to attend training in September 2014 on the InterRAI assessment tool.

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 Low

Evidence:

Wound assessment and wound management plans are in place for four residents (rest home) with six wounds and nine residents (hospital) with 11 wounds. This includes one pressure area (hospital). All have an assessment, management plan and evidence of timely review. The clinical manager and registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Finding:

One resident (rest home) has a new wound documented on an old assessment and treatment form and three residents (hospital) do not have all the documentation completed on the assessment form.

Corrective Action:

Ensure that there is a new wound assessment and treatment plan completed for each wound and that all documentation is completed on the wound assessment form

Timeframe (days): 90 *(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:

There is one activities coordinator who works 371/2 hours per week and one activities officer who works two days per week. There is a combined programme for the rest home and hospital level residents and includes one on one activity for residents who require these. On the day of audit, residents throughout the facility were observed being actively involved with a variety of activities. The programme is developed monthly and weekly activities are displayed in large print. Residents have an assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.
D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review/evaluated.
The programme includes networking within the community with social clubs, schools etc. On, or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept individual residents activities. There are recreational progress notes in the resident's file that the activity officers complete for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs in all areas of the facility, participation is voluntary.
The programme is comprehensive and designed for high end and low end cognitive functions and caters for the individual needs.
D16.5d Resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review.

The main activities officer drives the facility van on outings and has a current first aid certificate.

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:

Support plans are reviewed and evaluated by the registered nurse at least six monthly in three of six files sampled (one rest home resident and two hospital resident have been at the service less than six months). Plans are updated when changes to care occur in six of six files reviewed. The general practitioner has seen three residents (two rest home and one hospital) three monthly. Three residents have been at the service less than three months.
There are short-term care plans to focus on acute and short-term issues. From two of the six-sample group of resident's notes the short-term care plans (STCP) are well used and comprehensive. Examples of STCPs in use included; infections, unexplained weight loss and abscess. There are short-term care plans to focus on acute and short-term issues.
D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

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: FA

Evidence:

Medications are managed appropriately in line with accepted guidelines. There are two medication trolleys (rest home and hospital), three medication folders (one rest home and two hospital) and two treatment rooms (rest home and hospital). The medications are stored in locked trolleys in the treatment rooms. Controlled drugs are stored in a locked safe in the hospital treatment room and only the registered nurses have access to controlled drugs and two people (one being a registered nurse) must sign controlled drugs out. Registered nurses, enrolled nurses and senior caregivers administer medications and all must have passed their medication competency. List of competencies are in the front of the medication folders.
The service uses two weekly robotic sachets. Medication charts have photo ID's. There is a signed agreement with the pharmacy.
Robotic sachets are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.

Registered nurses and enrolled nurses are peer reviewed annually and caregivers are selected by the clinical manager and trained in medication administration and competency checked annually. Only those staff deemed competent administers medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off.
All 'medication competent' staff are responsible for medication administration in all areas. Competency tests are done annually and 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 – self administration policy (098) states self –administration of medication will be documented in the residents care plan.
There are currently four rest home residents self-administering inhalers, vitamins and medicated shampoo. Three monthly competencies are completed as sighted and medications are kept in a locked drawer in the residents rooms.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P.

The previous audit identified shortfalls around administering medications as directed, documentation on signing sheets and two signatures for controlled drugs. These shortfalls have now been addressed. All medication charts sampled have one signature per medication. All PRN medication prescriptions include an indication for use and a frequency for use. Signing sheets correspond to instructions on the medication chart for 12 of 12 medication charts sampled. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies,
The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the residents' general practitioner at least three monthly. Charts are easy to read and current. Medication audits are completed six monthly (February 2014).
The medication fridge is monitored daily and temperatures are all within the acceptable range. The controlled drug medications held have the correct labelling and prescribed for the resident. There is a weekly controlled drug physical check. All opened eye drops (eight) are dated.

Staff observed administrating medications safely and correctly included one senior caregiver in the rest home and one registered nurse in the hospital.

Medication management and administration education was held in April 2014.
D16.5.e.i.2; Nine medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed (three residents have been at the service less than three months).

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: 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 1.3.12.3 (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: 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:

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 and this last occurred in May 2014.
The service employs five kitchen staff including two cooks. The service is currently recruiting for a new head cook.

The main kitchen supplies meals for the rest home and hospital.
All of the five staff on the kitchen team at Tararu Home and Hospital have completed NZQA food safety certificates.
The service has a large workable kitchen that contains a walk-in pantry, two freezers, one fridge, one chiller, an air steam oven, bain marie, microwave, commercial oven and a hot box to deliver the hospital meals. There is a preparation area and receiving area.
Kitchen fridge, food and freezer, dishwasher, hot water and food on delivery temperatures are monitored and documented daily. 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) kitchen audit (March 2014 100%), b) environment kitchen hygiene (March 2014 100%), and c) food service audit (May 2014 98.2%).
Residents are able to request an alternative if they do not wish to have the prepared meal.
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 can be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets, low salt. protein drinks and diabetics.
There is a kitchen manual that includes but is not limited to hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety.
Daily temperature checks of the chiller, freezers, bain marie and dishwasher are maintained.
D19.2 Staff have been trained in safe food handling.

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:

The building holds a current warrant of fitness, which expires on 18 May 2015.

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.)*

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 (251) states the organisations philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident's quality of life however we acknowledge that there may be occasions when a resident's ability to maintain their own or another's safety may be compromised and the use of restraint may be clinically indicated'. There is a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. Restraint/enablers are also discussed in the quality meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.

The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has 10 residents (hospital) on the register with an enabler in the form of bedrails. Five files reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options.

The service currently has no residents on restraint. The service has been restraint free for one year.

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

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:

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

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

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 (registered nurse) 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 staff meetings (including a running register of multi resistant organisms, MRSA and ESBL). The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators.
Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks at the service.

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.

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.)*