Bupa Care Services NZ Limited - Whitby Rest Home & Hospital

Current Status: 29 September 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

Whitby Rest Home and Hospital is part of the Bupa group. The service provides hospital level services - medical/geriatric (24 beds), rest home care (18 beds) and dementia level care (31 beds) for up to 73 residents. Renovations are currently underway and ten rest home level beds have been closed during construction. During the audit there were eight rest home residents, 24 hospital residents and 29 dementia level residents residing in the secure dementia unit.

Two shortfalls identified in the previous audit have been addressed. These are around reporting clinical indicator data and reporting all incidents through the incident reporting process.

This spot surveillance audit identified further improvements that are required around dementia training for staff, aspects of clinical documentation and medicines management.

Audit Summary as at 29 September 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
(blue)	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
(green)	No short falls	Standards applicable to this service fully attained
(yellow)	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
(orange)	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
(red)	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 29 September 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.	(green)	Standards applicable to this service fully attained.

Organisational Management as at 29 September 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.	(yellow)	Some standards applicable to this service partially attained and of low risk.

Continuum of Service Delivery as at 29 September 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.	(yellow)	Some standards applicable to this service partially attained and of low risk.

Safe and Appropriate Environment as at 29 September 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.	(green)	Standards applicable to this service fully attained.

Restraint Minimisation and Safe Practice as at 29 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.	(green)	Standards applicable to this service fully attained.

Infection Prevention and Control as at 29 September 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.	(green)	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 - Whitby Rest Home & Hospital

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit		
Premises audited:	Whitby Rest Home and Hospital		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	**Start date:** 29 September 2014	**End date:** 30 September 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:	61

Audit Team

Lead Auditor	XXXXXX	**Hours on site**	12.5	**Hours off site**	8
Other Auditors	XXXXXX	**Total hours on site**	12.5	**Total hours off site**	8
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	25	Total audit hours off site	18	Total audit hours	43

Number of residents interviewed	5	Number of staff interviewed	8	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	68	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXXXX, 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 Monday, 3 November 2014

Executive Summary of Audit

General Overview

Whitby Rest Home and Hospital is part of the Bupa group. The service provides hospital - medical/geriatric (24 beds), rest home (18 beds), and dementia-level care (31 beds) for up to 73 residents. Renovations are currently underway and ten rest home level beds have been closed during construction. During the audit there were eight rest home residents, 24 hospital residents and 29 dementia level residents residing in the secure dementia unit.

Two shortfalls identified in the previous audit have been addressed. These are around reporting clinical indicator data and reporting all incidents through the incident reporting process.

This spot surveillance audit identified further improvements that are required around dementia training for one staff, aspects of clinical documentation and medicines management.

Outcome 1.1: Consumer Rights

Residents and relatives are kept informed at an organisational and facility level. Relatives interviewed confirmed they were notified of incidents/accidents and changes of the resident's health status. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards. There is a complaints register that is up to date and includes relevant information regarding each lodged complaint. Documentation including follow up letters and resolution demonstrates that complaints are well-managed.

Outcome 1.2: Organisational Management

Whitby Rest Home and Hospital 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. Whitby Rest Home and Hospital is benchmarked in three of these groups (dementia, rest home and hospital). The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to staff. Indicator data that is being reported in the meeting minutes and to head office is consistent with data that is being collected and is an improvement from the previous audit.

Individual incident reports are documented for each incident/accident with immediate action noted and any follow up action required. This is an improvement from the previous audit.

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. One caregiver who has been employed for longer than one year and is working in the dementia unit has not completed the required dementia education standard. This is a required improvement.

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 is managed by registered nurses (RN) who staff all shifts. Each resident has a dedicated registered nurse who is responsible for overseeing their individual care. The registered nurses are supported by a general practitioner who visits at least twice a week. Specialist advice is accessed as needed. All residents have an individual plan of care developed following their initial assessments taken on admission. Their plan of care is reviewed at least once every six months but usually more frequently when clinically indicated. Two further improvements were identified related to recording of clinical information.

There are group and individual programmes running in all areas. Activities are age appropriate, meaningful and reflect ordinary patterns of life. Residents interact with community groups and the facility van is used by the residents for community outings.

Medicines are managed appropriately and are in line with accepted guidelines with the exception of two areas which require further improvement. The medicine management policies are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up-to-date and reviewed by the general practitioner three monthly or earlier if necessary.

There are food service policies and procedures in place. Menu management is overseen by a dietitian. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Residents and relatives are satisfied with service delivery. The 2013 satisfaction survey results showed that 82% of respondents were satisfied with services received.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness which expires 24 June 2015. The building is currently undergoing extensive renovations.

Outcome 2: Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what a restraint is and what an enabler is. A process is in place for the assessment and evaluation of enabler and restraint use. The service has one hospital-level resident using bedrails as a restraint and two residents with bedrails as enablers. Enablers are assessed as being required for maintaining safety and independence and are used voluntarily. Training for staff has been provided around restraints, enablers and challenging behaviours.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme (IPC) and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager (RN) is the infection prevention and control coordinator. She is supported by head office staff, the facility GP and has access to laboratory advice and advice from the DHB IPC specialist team. The IPC programme is included in the quality programme which is reviewed annually. The surveillance policy describes and outlines the purpose and methodology for the surveillance of actual and suspected infections. The IPC register policy describes routine monthly infection surveillance and reporting. Surveillance is

described in full in the policy and occurs according to policy. Data is reported to head office and benchmarked between Bupa facilities. Data is reported by the clinical manager to facility staff at the monthly quality meeting held within the facility so that all staff are aware of IPC. The IPC programme is linked with the quality management programme. An outbreak of norovirus occurred early in 2014 in the dementia unit and was identified, contained within the dementia unit and fully resolved within six days.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	3	0	0	0
Criteria	0	35	0	4	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	34
Criteria	0	0	0	0	0	0	0	62

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	One of the five caregivers who are working on their dementia standards has been employed for over one year. She has completed two of her four dementia standards. The care home manager reports that she anticipates that this caregiver will complete her remaining two dementia standards in approximately two months' time.	Ensure all caregivers who work in the dementia unit are enrolled to complete their dementia standards in the first six months of employment and have completed their dementia standards within one year of employment.	180

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 1.3.3.3	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.	PA Low	The GP is not recording whether a resident's medical condition is stable when reviewing residents three monthly (refer ARC D16.5, e.I, 1). Care staff are not monitoring the urinary output of the resident with the xxxxx according to the plan of care.	Ensure the GP records in the resident's medical records that the resident's medical condition is stable if they intend to next review their health three monthly rather than monthly. Ensure clinical practice matches the requirements of the plan of care for the resident with the xxxxxxxxx	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
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 Low	A rest home resident is being supplied with controlled drugs on a regular basis from the hospital residents' impress stock of controlled drugs.	Ensure the bulk supply of controlled drug medicines occur according to the Medicine Care Guides published by the Ministry of Health.	30
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	One resident is self-administering medicines. This information was not noted on her medicine order and she was not storing them in a locked area when not in use.	Ensure the practice of self-administration of medicines occurs according to the Medicine Care Guides published by the Ministry of Health.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

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

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

Attainment and Risk: FA

Evidence:

Accident/incidents procedures and the 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, one unit coordinator registered nurse (RN) and all three caregivers interviewed state that they record contact with family/whanau on the family/whanau contact record (sited in five of five clinical records reviewed). Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. All fifteen incident forms reviewed for July and August 2014 identified that family were notified. As part of the internal auditing system, incident/accident forms are monitored, which includes auditing if families are kept informed. This was last completed by the service in April 2014 with a result of 100% compliance following the review of 20 incident/accident forms. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the residents' files.

D16.4b The eight relatives interviewed (three dementia, four hospital, one rest home) report that they are kept informed when their family member's health status changes or in the event of an accident/incident.

The Bupa communications manager keeps people informed and engaged about Bupa NZ's strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed. The care home manager publishes two-monthly newsletters for residents and family.

An interpreter's policy and a list of Language Lines and government agencies are available. The care home manager reports she would contact Hutt Valley District Health Board (HVDHB) in the first instance. In addition, there is a number of staff who are able to assist with interpreting for care delivery.

A policy on contact with media is available.

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

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

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.

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:

Information relating to the complaints process, including a complaints form, is included in the residents' information pack that is presented to residents and family during the admission process. Complaints brochures and complaints forms are also accessed at the entrance to the facility.

The care home manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint summary record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaints register. The number of complaints received each month is reported monthly to the quality and risk team via the facility benchmarking spread sheet.

Eight complaints have been lodged at the facility for 2014 (year-to-date). All eight complaints have been resolved. Documentation includes follow up letters and resolution. The documentation sighted indicates that complaints are well-managed. Verbal complaints are encouraged and actions and responses are documented. Discussions with eight relatives (three dementia, four hospital and one rest home) and five residents (four rest home and one hospital) confirm that they are provided with information on complaints. They also report that they would feel comfortable discussing a complaint or a concern with the care home manager and/or clinical manager.

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

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. Whitby Rest Home and Hospital has set specific quality goals for 2014 including: reducing the number of falls by residents in the facility by 10%; ensuring the facility is well-presented, free from unwanted smells, and appealing to visitors to the facility; improving resident satisfaction by 20%; improving team work and staff feeling valued with the role they perform by 20% on the staff satisfaction survey; and improving the staff engagement in the wellness programme by 20%; ensuring staff feel that they are treated as an individual as evidenced on the staff satisfaction survey.

Whitby Rest Home and Hospital provides hospital - medical/geriatric, rest home, and dementia-level care for up to 73 residents. Renovations are currently underway and ten rest home level beds have been closed during construction. There were eight of eight rest home residents (taking into account the ten closed rest home level beds); 24 of 24 hospital residents and 29 of 31 dementia level residents residing in the secure dementia unit.

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The organisation has a clinical governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in Health and Disability Commissioner (HDC) reports (learning's from other provider complaints) are also tabled at this forum. Three senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly. Feedback is provided to each facility (sighted).

The care home manager (RN) immigrated to New Zealand in 2006. She was the clinical manager for this facility for eight years and was appointed the care home manager in March 2014. She is supported by the clinical manager (RN) and the Bupa North Island Operations Manager. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

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

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.

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: FA

Evidence:

A quality and risk management system is in place. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, 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 Bupa Quality and Risk Team. Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents.

Key components of the quality management system link to the two-monthly quality committee. Weekly reports by facility manager to the central North Island operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager/assistant manager that break down the data collected across the rest home, dementia unit, and hospital unit. 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. Infection control is linked to the two-monthly quality meeting. Weekly reports from Bupa facility managers cover infection control (IC). Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee.

The health and safety committee meets three-monthly and is also an agenda item in the quality meetings. Health and safety and incident/accidents, internal audits are completed. 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. The monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, health and safety, accident reporting documentation, care planning and infection control. The frequency of monitoring is determined by the internal audit schedule. Indicator data that is being reported in the meeting minutes and to head office is consistent with data that is being collected. This is an improvement from the previous audit. There is evidence of the trending and analysis of quality data. Feedback is provided via graphs and benchmarking reports. This data is then presented to the care home manager. Results are discussed in the quality meetings and staff meetings (eg, RN meetings, caregiver meetings, support staff meetings). There is evidence of two corrective actions that have been developed in 2014 for reducing falls and reducing the frequency of urinary tract infections.

D19.3: There is a comprehensive health and safety (H&S) and risk management programme in place. Bupa has achieved the ACC Accredited Employer Programme at a tertiary level thru March 2015. Hazard identification, assessment and management policy guides practice. Bupa has a H&S coordinator who monitors staff accidents and incidents. There are four health and safety representatives and six committee members who sit on the Whitby Rest Home and Hospital health and safety committee. Health and safety meetings take place at Whitby every three months and include discussions relating to the analysis of incidents and accidents for both staff and residents, hazards management, health and safety training, audit results and ‘other’ (eg, health and safety concerns relating to the construction taking place). The hazard register was last reviewed in July 2014. The care home manager meets each week with the foreman of the construction group to ensure compliance with health and safety is being met at all times while construction is underway.

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: 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 1.2.3.7 (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 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).

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements can be made (link to finding 1.2.3.8). Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. This is an improvement from the previous audit. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.

Minutes of the quality meetings, staff meetings and health and safety meetings reflect discussions of results. Fifteen incident forms reviewed for July and August 2014 demonstrate clinical assessment and follow up by a RN/clinical manager following an adverse clinical event.

The care home manager is aware of the requirement to notify relevant authorities in relation to essential notifications. She reports that this has not been indicated since she was appointed to her role in March 2014.

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: PA Low

Evidence:

A register of RN, enrolled nurse (EN), GP, physiotherapist, podiatrist and pharmacy 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.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one registered nurse, one clinical manager, four caregivers) all had up to date performance appraisals. All staff files include a personal file checklist.

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

Interviews with the care home manager confirmed that newly appointed caregivers complete an orientation booklet that is aligned with foundation skills unit standards. On completion of this orientation, they have attained their first (level 2) national certificate. From this - they are then able to continue with core competencies level 3 unit standards. This aligns with Bupa policy and procedures.

There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. dementia, delirium. External education is available via the Hutt Valley DHB. There is evidence in RN staff files of attendance at the RN training day/s and external training. Discussions with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is a regular agenda item of the monthly quality meetings.

A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained. Signed competency questionnaires were sighted in all six reviewed staff files. A competency register is maintained by the care home manager. Staff interviewed are aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a council approved professional development recognition programme (PDRP). The nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At Whitby Rest Home and Hospital the care home manager has completed her PDRP.

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

Eighteen caregivers work in the dementia unit. Ten caregivers have completed their dementia standards and five are in the process of completing. Three caregivers have been employed for less than six months and have not yet enrolled in the programme. One of the five caregivers who is working on her dementia standards has been employed for over one year. She has completed two of her four dementia standards. The care home manager reports that she will complete the programme in approximately two months' time.

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: PA Low

Evidence:

There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. dementia, delirium. External education is available via the HVDHB. There is evidence on RN staff files of attendance at the RN training day/s and external training. Discussions with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is a regular agenda item of the monthly quality meetings.

A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained. Signed competency questionnaires were sighted in all six reviewed staff files. A competency register is maintained by the care home manager. Staff interviewed are aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a council approved professional development recognition programme (PDRP). The nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At Whitby Rest Home and Hospital the care home manager has completed her PDRP.

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

Eighteen caregivers work in the dementia unit. Ten of eighteen caregivers and the activities recreation coordinator who works in the dementia unit have completed their dementia standards and five of eighteen caregivers are in the process of completing theirs. Three caregivers have been employed for less than six months and have not yet enrolled. One of the five caregivers who is working on her dementia standards has been employed for over one year.

Finding:

One of the five caregivers who are working on their dementia standards has been employed for over one year. She has completed two of her four dementia standards. The care home manager reports that she anticipates that this caregiver will complete her remaining two dementia standards in approximately two months' time.

Corrective Action:

Ensure all caregivers who work in the dementia unit are enrolled to complete their dementia standards in the first six months of employment and have completed their dementia standards within one year of employment.

Timeframe (days): 180 *(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 that aligns with contractual requirements and includes skill mixes. The wage analysis schedule is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours.

The roster is flexible to allow for the increase of hospital residents or rest home residents.

Staffing is as follows:

Monday-Friday: care home manager (RN) and clinical manager (RN) on a full-time basis.

In the rest home one caregiver is scheduled for on the morning (0700 -1500), one in the afternoon (1500 – 2300) and one at night (2300 – 0700).

In the hospital, the clinical manager oversees clinical operations Monday – Friday. She is assisted by an additional RN on each shift (morning, afternoon and night). Four caregivers work during the morning shift (two short shifts and two full shifts), four caregivers work during the afternoon shift (one short shift and three full shifts) and one caregiver is scheduled to work during the night shift.

In the dementia unit, there is a unit coordinator (RN) who is employed from 0800 – 1600 Monday – Friday. She is assisted by four caregivers on the morning and afternoon shifts (one short shifts and three full shifts), and two caregivers work on the night shift.

Three caregivers interviewed across the three areas (dementia, hospital and rest home) report that staffing is adequate to meet the needs of the residents. This was also confirmed in interviews with five residents (four rest home and one hospital) and eight relatives (three dementia, four hospital and one rest home).

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: PA Low

Evidence:

D16.1: Residents are welcomed and orientated to the facility by a registered nurse (RN) who will then begin the assessment process. Each resident has a nominated registered nurse who is responsible for their care in addition to the unit coordinator of the dementia unit (who is and RN) and the clinical manager (RN) who oversees both the rest home and hospital residents. Care is provided by a mix of registered nurses and caregivers (observed and confirmed in discussions with the clinical manager, the dementia unit coordinator and three of three caregivers).

Each resident has an initial assessment by a RN on the day of admission. This information is then used to develop the initial plan of care which is developed on the day of admission (confirmed in review of five clinical records (i.e., one rest home resident, two dementia unit and two hospital residents). Over the next three weeks a number of more detailed assessments are undertaken and this information is used to inform the long term care plan. Physiotherapy assessments, management plans and transfer plans are completed by the physiotherapist. The activities coordinators complete ‘the day in a life of’ and activities section of the care plans.

A long term plan of care is developed by a registered nurse within three weeks of admission. All care is overseen by registered nurses. The facility is staffed by registered nurses twenty four hours a day, seven days a week. More than one RN is usually on duty during the daytime in the working week. RNs are also on call to provide additional support if needed.

D16.2, 3, and 4: Plans of care are reviewed by a RN and amended when the resident’s current health changes and care is evaluated at least six monthly.

D16.5e: Each resident is reviewed by their GP within 2 days of admission. After the initial examination residents are seen at least monthly or three monthly if their medical condition is assessed as stable. It was noted that the GP was not systematically recording whether the resident’s medical condition was stable when reviewing residents three monthly and an improvement is required (refer 1.3.3.3 below). The GP was interviewed and the matter discussed. She is satisfied with the standard of care provided at the facility and has confidence in the RN decision-making.

E4.2 (a): There is a record of the identifying behaviours for each resident in the dementia unit which is documented in the Bupa “My Day My Way” document

E4.4 (d): The involvement of family/whanau is promoted at all times for residents in the dementia unit (Family were observed participating in the six monthly review process and interacting with staff when visiting).

Residents (i.e., four rest home, and one hospital) and families (i.e., one rest home, three dementia, and four hospital) interviewed all stated they felt that care needs were being well met by staff.

Hospital tracer:

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

Rest home 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: PA Low

Evidence:

The GP is examining residents on a regular basis and recording findings and plans of action in their medical records. A review of the medical records of two of the five clinical records in the sample evidenced that the GP had not been recording whether the resident's medical condition was stable when reviewing residents three monthly. The sample was extended, which confirmed that the practice was systemic and the omission was a recent change in practice. The clause in the Agreement was discussed with the GP in person during the audit.

Service provision for one resident who has XXXXXXXXXXX is not occurring according to her plan of care for her XXXXXX. The plan of care requires that her urinary output will exceed a certain minimum amount over a period of time otherwise actions must occur. On the day of audit no records were being maintained of her urinary output in any consistent manner over each 24 hour period and this had been the case for some time. Staff were periodically recording output in progress notes but records were intermittent or non-existent. The matter was discussed with the clinical manager and rectified immediately. A urinary output recording system was implemented.

Finding:

The GP is not recording whether a resident's medical condition is stable when reviewing residents three monthly (refer ARC D16.5, e.I, 1). Care staff are not monitoring the urinary output of the resident with the XXXXXXXX according to the plan of care.

Corrective Action:

Ensure the GP records in the resident's medical records that the resident's medical condition is stable if they intend to next review their health three monthly rather than monthly.

Ensure clinical practice matches the requirements of the plan of care for the resident with the XXXXXXXX.

Timeframe (days): 60 *(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 1.3.6: 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 (with the exception of one resident refer 1.3.3) (evidenced through clinical records review of five of five clinical records (one rest home, two dementia and two hospital level residents), interviews with five residents (four rest home, one hospital), eight families (one rest home, four hospital and three dementia), and interviews with staff (one clinical manager, one unit coordinator (dementia unit), three caregivers, one activities recreational coordinator-dementia unit) and the GP.

Residents' care plans are completed by registered nurses. Care delivery is recorded and evaluated by caregivers or registered nurses on each shift. When a resident's health status changes, the registered nurse initiates a review and if required arranges for a GP or specialist consultation. The families interviewed confirmed they are informed if there has been a change in health status.

The clinical manager, unit coordinator dementia unit and three caregivers interviewed (who work in all areas and on all shifts) stated that they have all the equipment referred to in care plans and necessary to provide care, including hoists, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Equipment if needed is provided promptly by Bupa.

Staff have access to specialist care services as needed. Staff report that there is sufficient stocks of continence products and dressing supplies (observed during tour of the facility).

Residents (i.e., four rest home and one hospital) stated that they feel well cared for. Eight family members interviewed (i.e., one rest home, three dementia and four hospital) are very positive about the care that residents receive.

Wound assessment and wound management plans are in place for nine residents (three rest home residents and six hospital). The rest home residents had six wounds in total (i.e., five skin tears and one vascular ulcer which is under general practitioner management and has been referred back to the general practitioner by the wound nurse Capital and Coast DHB). The hospital residents had 12 wounds in total (five pressure areas (one Grade 4, and four Grade 2s), and five other types of wounds (i.e., not pressure areas, skin tears or ulcers or caused by trauma (two of which are the open area wounds). One of the six residents in the hospital area had small pressure areas and he has been seen and discharged by the wound nurse Capital and Coast DHB (The resident's care was reviewed. He is receiving end of life care and his pain is being managed). The rest home resident with the ulcer is being considered for referral to the vascular service. No residents in the dementia unit have wounds. There are corresponding short-term care plans evident for wounds and these are filed in the wound management folder.

There is a comprehensive education programme in place for staff some of which requires mandatory attendance by staff. Examples of education provided in 2014 has included the following: wound management competencies (January 2014), pain assessment and management (February 2014) for RNs, Falls prevention (February 2014), Catheterisation (March 2014), First aid for the choking resident (April 2014), taking physical and neurological observations (May 2014), caring for residents with dementia (May 2014), caring for residents with delirium (May 2014), First Aid training (June 2014), giving oxygen and nebulisers (June 2014), the aging process (July 2014), caring for residents who exhibit behaviours that may challenge (July 2014), diabetic management for RNs and taking blood sugar levels (August 2014). Staff report there are multiple training opportunities offered within Bupa and that there is always some training being offered (confirmed in discussions with the facility manager, the clinical manager and three of three caregivers).

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.

E4.3(a),(b)(i-(iv) Each resident in the dementia unit has a plan of care that takes into account their needs and guides the staff on how to manage their behaviours over a 24 hour period.

E4.4c: Staff endeavour to build a relationship with residents in the dementia unit depending on their level of dementia and ability to communicate.

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

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

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

Attainment and Risk: FA

Evidence:

The service is staffed by two activities recreational coordinators (one works in the dementia unit (interviewed) and the other provides the programme for the rest home and hospital residents. Both activities recreational coordinators are overseen by an occupational therapist from head office as neither have diversional therapy qualifications.

The activities recreational coordinator who works in the dementia unit is a trained primary teacher who has completed the required dementia training and other training over the years. She has been employed in the role for 11 years. The other activities recreational coordinator has been employed in the role for three years. The activities recreational coordinator who works in the dementia unit works six hours a day, five days a week, Monday to Friday from 9.30 to 4pm. The other works from 9 am to 4pm Monday to Friday. The programme is provided by caregivers in the remaining hours.

There is a variety of group and individual activities offered to all residents depending on their preferences. There are lists of individual activities to guide staff when the activities recreational coordinators are not onsite.

Examples of activities include: physical (eg, exercises, walks, dancing, games (eg bowls, skittles, darts, volley ball), cognitive (eg, newspaper readings, books, poetry, bingo, quizzes, word games), sensual (eg, massages, hair/beauty therapy, water therapy, pet visits, cooking, gardening), social (eg, theme days, celebrating special days, outside entertainers, Films/DVDs). Residents are able to go on outings using the facility's 12 seated van which can take nine residents at a time plus the driver and staff. A driver is employed to drive the van and the activities staff usually accompany the residents. The activities recreational coordinators have current first aid certificates.)

There are two separate programmes running that are both meaningful and reflect ordinary patterns of life. The programmes will mix on occasions for external visitors. There is evidence of the wider community involvement with regular outings, church services and school groups visiting. The programmes are developed weekly off a monthly programme and displayed in large print throughout the facility. Residents are given opportunity to feedback on the programme through the resident meetings and other avenues (eg, the compliments/complaints system and the satisfaction survey). Residents spoken to report satisfaction with the activities programme.

All residents have a complete assessment completed over the first few weeks after their admission by the activities recreational coordinators who obtain a complete history of past and present interests, career, family etc. and this information is documented and influences the plan of care. A record is kept of individual residents activities in the activities participation register form. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan and is involved in the six monthly multidisciplinary review of the plan. .

D16.5d The programme includes group and individual activities and involvement with the wider community. Information related to preferred activities and level of involvement is documented in five of five resident records sampled (one rest home, two hospital and two dementia). Individual preferences are noted in the resident's initial assessment and their involvement in activities is evaluated and reviewed as part of the care plan review.

E4.3 Each resident in the dementia unit has an individual diversional therapy plan in place covering the 24 hour period which reflects their former routines and activities that are still familiar to the resident. This is documented in the "My Day My Way" document.

E4.5 There is a designated person skilled to oversee the programme, which is the occupational therapist employed at Bupa Head office. The occupational therapist provides support and training to the activities recreational coordinators (last provided Sept 23 2014 when the focus was on how to provide male focused activities). Both coordinators can telephone the occupational therapist anytime for advice.

The results of the 2013 satisfaction survey showed that no respondent expressed dissatisfaction with the activities programme and the majority (i.e., 81%) rated the activities and events as good to excellent. Residents and relatives interviewed (i.e., five of five residents (four rest home and one hospital) and eight of eight relatives (one rest home, four hospital and three dementia) expressed satisfaction with the activities programme.

The activities programme is part of the internal audit programme within the facility and was last audited 21 July 2014 with no corrective actions identified.

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:

The process for evaluation occurs as follows: Each resident has a review of their initial plan of care within three weeks of admission and a long term care plan is developed to guide service delivery. Each resident has a three monthly review of their medicine regime, which is done by the RN and their general practitioner. Each resident has a multidisciplinary review (MDR) of their long term care plan which occurs six-monthly. Each resident is assessed more frequently if their health changes or a review is requested by staff or family. There is a schedule of reviews to guide staff (sighted). The clinical manager and dementia unit coordinator maintain a resident MDR review schedule (displayed in office) which lists when reviews are due and or happened to ensure all reviews occur in a timely manner The MDR is planned to coincide with the resident’s three monthly medicine review. Staff will notify family of the intention to hold a MDR meeting and invite them to the meeting and an agreed date is set. Prior to the meeting the caregivers on all shifts for the preceding two weeks are asked to fill in the resident needs data collection sheet, which covers care needs on all shifts. The data collection sheet is also completed by the activities staff, plus any RNs working with the resident. The unit coordinator or an RN will then review the care planning documentation (eg, the care summary form, the transfer plan, the care plan and the assessment). The GP will review the resident usually before the meeting rather than at the meeting. The resident is then reviewed six monthly or earlier if there is a significant change in their health status. Comprehensive evaluations were occurring in a timely manner (confirmed in review of five of five resident records (one rest home, two hospital and two dementia)) and in discussions with the clinical manager and the dementia unit coordinator plus the activities recreational coordinator in the dementia unit).

Care plans are reviewed as part of the internal audit process (last audit was conducted in 30 May 2014 which resulted in no corrective actions being identified).

D16.4a: Care plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur.

Short term care plans are used for health issues that are not expected to be permanent (eg, infections, wounds, behaviours that challenge and unexplained weight loss). These are reviewed at least weekly by an RN. A list of residents with short term care plans in place is listed on office white boards to remind staff so that everyone providing care is aware of the special needs. Changes to the long-term care plans are made as required and at the six monthly review if required.

Residents and relatives interviewed (five of five residents (four rest home and one hospital) and eight of eight relatives (one rest home, four hospital and three dementia) confirm they are involved in the review process.

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: PA Low

Evidence:

Residents have their medicines prescribed on entry by the general practitioner and their medicine regime is reviewed at least three monthly to ensure continuity of supply. Medicines are dispensed by one contracted pharmacy (contract sighted). The pharmacy delivers medicines fortnightly unless they need to deliver newly prescribed medicines. Reconciliation is managed by the registered nurses as stock is delivered before the medicines are used. All medicines are administered by registered nurses or a medicines competent caregiver. The RNs assess each other's competency and assess the competency of caregivers (competencies sighted and confirmed in discussions with the clinical manager, the dementia unit coordinator and three of three caregivers). Medicine rounds were observed in all areas and occur according to policy. Medicines are stored in specialised trollies which are stored in dedicated medicine rooms (one in each area). There are dedicated medicine refrigerators and temperatures are monitored. Controlled drugs are stored appropriately. There is a record of weekly checking of controlled drugs and review by the pharmacy (last reviewed 23 June 2014). Controlled drugs are managed by imprest stock. Imprest stock of controlled drugs is being used for one rest home resident, which is inconsistent with the Medicine Care Guides for bulk supply and an improvement is required (reference 1.3.12.1 below). Medicines no longer in use are returned to the pharmacy. One hospital level resident is self-administering medicines and the system does not comply with the Medicine Care Guides. An improvement is required (reference 1.3.12.5 below). Standing orders are not used by the registered nurses. Warfarin management occurs according to policy.

D19.2 d Medication is managed safely and appropriately in line with accepted guidelines. Ten medication charts were sampled (i.e., three hospital, three rest home, and four dementia unit).

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.

Attainment and Risk: PA Low

Evidence:

One rest home resident is being issued with controlled drugs on a regular basis from the hospital imprest stock and does not have an individually dispensed supply, which is inconsistent with the Medicine Care Guides for bulk supply.

Finding:

A rest home resident is being supplied with controlled drugs on a regular basis from the hospital residents' imprest stock of controlled drugs.

Corrective Action:

Ensure the bulk supply of controlled drug medicines occur according to the Medicine Care Guides published by the Ministry of Health.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

One resident is self-administering medicines. This information was not noted on her medicine order and she was not storing these medicines in a locked area accessible only to herself and staff. These practices are inconsistent with the Medicine Care Guides. Her room does not contain a lockable area and her bedroom door is not able to be secured.

Finding:

One resident is self-administering medicines. This information was not noted on her medicine order and she was not storing them in a locked area when not in use.

Corrective Action:

Ensure the practice of self-administration of medicines occurs according to the Medicine Care Guides published by the Ministry of Health.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service employs two cooks and three kitchen staff (main cook interviewed). The kitchen supplies meals for all areas. Food is transported by Bain Marie or covered hot plate directly by the cook from the kitchen. All kitchen staff have completed food safety certificates. The service has a large workable kitchen that contains one walk-in dry store/office, a freezer, domestic refrigerators (with snacks for all areas), a commercial oven, bain maries, a microwave, and a gas hob. There is a preparation area and receiving area. Food is delivered by commercial suppliers and there is a waste removal system in place. Kitchen fridge, food and freezer temperatures are monitored and documented daily (sighted). There is a cleaning schedule in place and a national menus policy 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 (last reviewed March 2013).

All residents have a nutritional profile developed on admission which identifies their dietary requirements and likes and dislikes. This information is delivered to the kitchen staff by the admitting RN. This information is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as needed. 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 a gluten free diet. Caregivers mix supplementary feeding. Kitchen staff are made aware of weight management plans

The resident annual satisfaction survey includes the food service (results in 2013 showed that 79 percent rated the food service good to excellent and only 4 percent of respondents were dissatisfied with the food service).

The kitchen is included in the internal audit programme. There are a number audits completed which include; a) environment kitchen – last conducted June 2014, b) food storage audit –last conducted August 2014, and c) food service audit last conducted May 2014. There were no outstanding corrective actions required from the internal audits.

E3.3f: There is evidence that additional nutritious snacks are available over 24 hours for all residents in all areas. Residents in the dementia unit have access to snacks between meals.

Residents' weights are monitored by RNs. Where significant weight loss or gain is identified residents are placed on a weekly weight chart. Supplements are available and described by caregivers.

Residents can choose to have breakfast in their room. Staff take trollies around and freshly cooked eggs are delivered as cooked from the kitchen by the cook personally.

Mini Nutritional Assessments are completed on admission and repeated six monthly and identify those residents at risk of malnutrition.

Residents and relatives are satisfied with the meals provided (confirmed in discussions with five of five residents (i.e., one of one hospital and four of four rest home) and eight of eight relatives (i.e., one rest home, four hospital and three dementia unit).

The kitchen stores at least three days of food to ensure residents and staff can be fed if supplies are disrupted due to a civil defence emergency.

The kitchen was the subject of a complaint to the Council recently by disgruntled staff member. The Council inspected the premises and stated they were happy with the overall standard of the kitchen. They recommended that management repair a join in the flooring when conducting routine maintenance. The Council did not view the repair as being urgent and in the meantime temporary repairs have been implemented.

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:

A current building warrant of fitness is posted at the entrance to the facility (expiry 24 June 2015). A fire evacuation plan is in place. This plan has been altered during the build that is currently in place. The care home manager reports that the foreman is in regular contact with the local fire service. If an exit is removed, an approved alternate is established with appropriate signage in place. This was evidenced during a walk-through of the facility. A new fire evacuation plan will be sent to the fire service for approval once construction is completed.

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:

A restraint policy is in place. There are documented definitions for restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures.

Assessment and evaluation procedures for enabler and restraint use are in place. The service has one hospital-level resident using bedrails as a restraint and two residents with bedrails as enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by residents.

Education and training has been provided around restraint, enablers and challenging behaviours. This includes staff completing annual competencies.

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.)*

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 clinical manager (RN) is the infection prevention and control (IPC) coordinator. She has been in the role since she was appointed in April 2014. She has been a clinical manager with IPC responsibilities for Bupa at a previous Bupa site since 2012. She is supported by head office staff and the facility GP and has access to laboratory advice and advice from the DHB IPC specialist team. The IPC programme is included in the quality programme which is reviewed annually. The IPC committee is the clinical manager in consultation with the RNs. The surveillance policy describes and outlines the purpose and methodology for the surveillance of actual and suspected infections. The IPC register policy describes routine monthly infection surveillance and reporting. Surveillance is described in full in the policy; responsibilities and assignments are described and documented. Data are collected individually and collated monthly by the clinical manager. She reports the data to quality and risk staff at head office. They collate the data over time and over facilities and provide a monthly report of year to date numbers and rates back to the IPC coordinator. Data are also reported by the clinical manager to facility staff at the monthly quality meeting held within the facility so that all staff are aware of IPC. The meeting agenda includes the monthly IPC report. The IPC programme is linked with the Quality Management Programme. Quality Improvement initiatives are taken and recorded as part of continuous improvement.

There was an outbreak of Norovirus on 24 Feb 2014 which affected 20 residents and 4 staff in total and was completely resolved by 29 Feb 2014. The outbreak was contained within the dementia unit and did not spread throughout the rest of the facility, which is excellent IPC management in the circumstances.

The IPC programme is included in the internal audit programme (last internal audit was 30 June 2014 for standard precautions and hand washing. The score was 85% compliance. Corrective actions were identified and implemented which involved staff retraining. A follow-up audit on 8 September 2014 showed that compliance had improved to 99.6% and the corrective actions are now closed out).

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.)*