# Bupa Care Services NZ Limited - Rossendale Dementia Care Home & Hospital

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** Rossendale Dementia Care Home & Hospital

**Services audited:** Hospital services - Psychogeriatric services; Dementia care

**Dates of audit:** Start date: 16 December 2014 End date: 17 December 2014

**Proposed changes to current services (if any):** The service converted six existing dementia beds to hospital (psychogeriatric) level care

**Total beds occupied across all premises included in the audit on the first day of the audit:** 94

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Rossendale Home and Hospital is part of the Bupa group. The service provides hospital (psychogeriatric) level care and rest home (dementia) level care for up to 100 residents. There are five beds that can be used for either psychogeriatric or hospital (geriatric) residents. On the day of the audit there were 77 hospital (psychogeriatric) residents and 17 rest home (dementia) residents. There were no hospital (geriatric) residents Rossendale’s care home manager and clinical manager are well qualified for their roles. Staff turnover remains low.

There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Rossendale. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit has identified no areas requiring improvement. Continuous improvements have been awarded against good practice, organisational values, data analysis and team development.

## Consumer rights

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| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Bupa Rossendale provides care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and supporting policies that are being implemented policy. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support resident rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Family members interviewed verified on-going involvement with community. A continuous improvement was been awarded around good practice.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Rossendale is implementing the organisational quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Rossendale is benchmarked in two of these (psychogeriatric and dementia). There are human resources policies including recruitment, selection, orientation and staff training and development. The service a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Continuous improvement has been awarded around organisational values, data analysis and team development.

## Continuum of service delivery

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| 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. |  | Standards applicable to this service fully attained. |

There is a comprehensive admission pack provided on entry to the service. All residents have a needs assessment prior to admission. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the long term support plan to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. The activities team implements the activity programme to meets the individual needs, preferences and abilities of the residents. One on one time is spent with individual residents. Community links are maintained. There are regular entertainers, outings, and celebrations. Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the General Practitioner. All baking and meals are prepared and cooked on-site. Residents' food preferences and dietary requirements are identified at admission. This includes consideration of any particular dietary preferences or needs.

## Safe and appropriate environment

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| 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. |

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. There is a spacious lounge and dining area and smaller lounges available in each unit within the facility for quieter activities or visitors. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has two residents on the register with an enabler in the form of wheelchair lap belts and 25 assessed as using a restraint, ether a lap belt or bedrails with two residents utilising both. Restraint is used for the minimum time and monitoring is documented. A register is completed that includes a three-monthly evaluation. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

## Infection prevention and control

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| 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. |

The infection control programme is appropriate for the size and complexity of the service. There are appropriate policies and guidelines for the scope of the programme. The infection control officer is a registered nurse and is responsible for providing education and training for staff. The infection control officer has attended recent training and is supported by the organisations quality and risk team. The infection control co-officer uses the information obtained through surveillance to determine infection control activities such as education and internal audits within the facility.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 96 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | On admission families (and residents) are provided with information that includes a copy of the Health and Disability Commissioners Code of Health and Disability Services Consumers' Rights (the Code). Staff receive ongoing training about the Code. Interview with six caregivers demonstrates an understanding of the Code and how they incorporate the various aspects into daily cares. Eleven relatives interviewed confirm staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code. Completed resuscitation treatment plan forms were evident on all resident files reviewed. There is evidence of general practitioner (GP) and family discussion regarding a clinically not indicated resuscitation status. General consent forms were evident on files reviewed. Discussions with six caregivers and seven registered nurses (RNs) confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed with the admission agreements. Where legal processes are ongoing to gain EPOA this is recorded, as are letters of request to families for the supporting documentation. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code and advocacy pamphlets on entry. Interviews with the care home manager, the administrator and the clinical manager confirm that practice is consistent with policy. Interviews with relatives confirm that they are aware of their right to access advocacy and that there are opportunities to be involved in decisions. The resident files include information on residents’ family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The activities programmes include opportunities to attend events outside of the facility including activities of daily living. Interview with staff and family confirm that residents are supported and encouraged to remain involved in the community as able. Family confirm they can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints received are managed by the care home manager. The 2014 complaints were reviewed and there was a complaint management record completed for each complaint. All complaints had been investigated with appropriate documentation on record. A record of complaints each month is maintained by the facility on the complaint register. The number of complaints received each month is included in the Bupa benchmarking programme. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. Interview with relatives confirm they were provided with information on complaints and that a complaints procedure is provided to residents within the information pack at entry. A quality initiative for the service has been to reduce the number of complaints, the service is on track to meet this aim with 22 complaints recorded for 2013, and at the time of audit there had been 12 received across 2014. The service is proactive in implementing actions following complaints examples including improvement to restraint monitoring and development of three lounge areas in the hospital offering different levels of stimulation for residents (also refer 1.2.3.6). |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The information pack provided to residents on entry includes how to make a complaint, the Code pamphlet, information about advocacy services and the Health and Disability Commission. The care home manager and registered nurses described discussing the information pack with residents/relatives on admission. The two monthly family meetings also provide the opportunity to raise issues/concerns (minutes sighted). Relatives interviewed inform information has been provided around the Code. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. Ten resident files reviewed identified that individual preferences, including cultural and spiritual values, are identified on admission and then integrated into the resident's care plan. Instructions are provided to residents/relatives on entry regarding responsibilities around personal belongings in their admission agreement. Personal belongings are seen in resident rooms. The service encourages residents to have choice where able such as voluntary participation in daily activities.  Interview with six caregivers (one from the dementia unit, one from the high dependency unit and four from the psychogeriatric unit) described how choice is incorporated into resident cares. Interviews with family members (six psychogeriatric and five dementia care) were extremely positive about the care provided. There is an abuse and neglect policy that is being implemented and staff attend in-service education on the topic.  The care home manager is the privacy officer. A tour of the facility confirms there is the ability to support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms.  A resident/family satisfaction survey was completed in November that resulted in an 89% overall satisfaction with the service – including 90% of respondents indicating they were satisfied that staff took the time to know residents, and 93% believed staff were well trained. This is an increase from the previous year where overall satisfaction was rated at 83%. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Bupa has a Maori health plan and supporting policies that acknowledge the Treaty of Waitangi and provide recognition of Māori values and beliefs. Guiding documents were developed in consultation with Kaumatua and there are contact details of local iwi available. Family/whanau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. While there were Maori residents in the service, no relatives were available to be interviewed during the audit. Interview with six caregivers could describe cultural appropriate practices. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Initial (and ongoing) care planning with the resident and/or whanau identify beliefs or values that are to be incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with eleven relatives inform values and beliefs are considered. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The code of conduct is included in the employee pack. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. The enrolled nurses work under the direction and supervision of the registered nurses (RN’s). There are appropriate policies to guide staff practice. Clinical meetings occur monthly (held with registered staff) and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirm an awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | Bupa has a robust quality and risk management framework that is being implemented at Rossendale. The framework ensures services adhere to the health & disability services standards. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. This group meets every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. The Bupa geriatrician provides newsletters to general practitioners (GPs). Staff at facilities are encouraged to provide feedback on proposed changes to policy which are forwarded to the chair of the review committee. Technical experts are called upon as required. All facilities have a master copy of all policies and clinical forms. A number of clinical practices also have education packages for staff which are based on their policies.  There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants. There are required competencies for different staff types, and these are up to date at Rossendale. There is an annual education programme that is being implemented at Rossendale. ‘Tool box’ sessions, which are focused discussions with staff following for example a particular incident, are also seen to be provided regularly at Rossendale. Seven RNs interviewed confirmed they have access to external training and that the care home manager is supportive of ongoing learning.  Bupa has a strong focus on clinical benchmarking, both nationally and internationally. Nationally there are four benchmarking groups that compares clinical indicators across the different service levels. These are rest home, hospital, dementia, and psychogeriatric/mental health. Rossendale is benchmarking is against the psychogeriatric and dementia service levels. Trending data is provided to the service monthly and corrective actions are required to be completed when trends are above the prescribed benchmark. Rossendale had implemented and closed out corrective actions as required. The service has also developed two focus groups that has positively impacted on the rate of falls and resident behaviour (refer 1.2.3.6). Staff are kept informed of the incident trends via meetings and information kept in the staff room.  Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). Of the 97 care staff at Rossendale, all have achieved bronze, 37 silver and 35 gold.  Annual staff and resident/relative survey results indicate a high level of satisfaction with the service. Interview with eleven relatives were positive about the care they receive. A continuous improvement has been awarded. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure that guides staff in their responsibility to notify family of any accident/incident that occurs. Accident/incident forms include a section to indicate if family have been informed (or not) of an accident/incident. Twenty seven incident forms were reviewed from November 2014 across both service types. Family had been notified appropriately in all instances. Appropriate management of incident reporting is included in the internal audit programme and as part of the annual education programme. Corrective actions are completed when required and tool box sessions are used to increase staff awareness of reporting responsibilities.  There is an interpreter policy and staff are aware of how to access interpreters if required. There are a number of residents (and staff) from a variety of cultures and family interviewed were particularly complimentary of how staff are able to communicate with residents where English is a second language. The eleven relatives stated that they are informed when their family members health status changes  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. 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. The information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa has a quality and risk framework that is being implemented at Rossendale. There is an overarching business plan and risk management plan for the organisation. Each facility then develops quality goals for the year. Rossendale goals for 2014 include reducing falls, pressure areas, skin tears and resident behaviours. Progress towards these goals is minuted in the various meetings held at the service. Rossendale’s care home manager is a registered nurse who has been in post since 2009. She is supported by a clinical manager appointed to the role in February this year. The care home manager is supported by a regional manager who in turn is supported by the organisations clinical and management infrastructure. This infrastructure includes regular meetings, six monthly forums and a national conference which managers attend. The care home manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a hospital.  Rossendale provides care for up to 100 residents across two levels – hospital (psychogeriatric) and rest home (dementia). Rossendale is the only service with psychogeriatric beds in the region. The hospital residents (psychogeriatric) are cared for in three units – a 10 bed high dependency unit, a 23 bed psychogeriatric unit and a 50 bed hospital unit. In addition the service has previously had five beds in the hospital unit approved as dual purpose so end of life care can be provided for residents if required.  This audit also included verifying six previous dementia level beds that have been moved to the hospital (PG) unit. The rooms, and staffing was identified as appropriate to provide specialist hospital care.  A continuous improvement has been awarded at criterion level. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The care home manager and clinical manager alternate on call responsibilities and there is a guideline available for staff to support decision making in respect of contacting management afterhours. The care home manager and clinical manager are not on leave at the same time. The operations manager is also available to provide oversight and support. |
| 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. | FA | Bupa has a comprehensive quality and risk management system that is being implemented at Rossendale. The quality programme includes monthly benchmarking by service type. Rossendale benchmarking against rest home (dementia) and hospital (psychogeriatric) care. Benchmarking is also undertaken in respect of infection rates and restraint usage. Rossendale is unique in that they are a large hospital (psychogeriatric) service and benchmarking ‘like against like’ is therefore challenging. Benchmarking data is discussed at the monthly quality meetings and then at the various staff meetings. Rossendale has an active health and safety committee that collates and discusses staff incidents /accidents. This data is also aggregated at an organisational level and reported monthly. The health and safety committee monitor objectives that are defined in the Bupa Health & Safety Plan. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.  Bupa policy review committee develop organisational policies appropriate for aged residential care services that align to current accepted practice. Policies are reviewed regularly and facilities are encouraged to have input into their review. Reviewed policies demonstrate feedback from relevant technical experts. There is a document control process being implemented that ensures the most current document is in use in clinical areas.  Bupa prescribe an annual internal audit programme that is being implemented at Rossendale. Corrective action plans are developed and seen to be closed out at the time of audit. Rossendale also develops corrective action plans where monthly benchmarking outcomes rate above the accepted threshold. Staff are informed of audit outcomes and involved in corrective action plans.  A continuous improvement has been awarded at criterion level. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service collects incident and accident data. The 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 (definitely within 24 hours of the event), even if an investigation is on-going. Twenty seven incident forms were reviewed across November 2014 in the hospital and dementia unit. All forms were completed appropriately, including clinical manager (or delegate) review and sign out. Families were reported as having been informed as appropriate in all reviewed. 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. A corrective action plan is required when an indicator exceeds the key performance indicator (KPI) rate by 3.0. Rossendale is proactive in developing and implementing corrective action plans (refer 1.2.3.6). The four 2014 quality goals for the service focus on reducing KPI rates and this has resulted in the development of two focus groups – behaviour and falls. The work being undertaken is demonstrating a reduction in the number of reported incidents (refer continuous improvement awarded against 1.2.3.6). Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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. | FA | There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files were reviewed and all had personal file checklists. Performance appraisals were current in all files reviewed. 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 and includes documented competencies. New staff are buddied for a period of time. Staff interviewed stated that they believed new staff were adequately orientated to the service. As part of their orientation care givers complete a booklet that has been aligned with foundation skills unit standards, effectively attaining their first national certificates. There is an annual education schedule that is being implemented and an RN/EN training day provided through Bupa that covers clinical aspects of care. External education is supported a Rossendale. A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained. Staff interviewed is aware of the requirement to complete competency training. Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. There is a staff member with a current first aid certificate on every shift. All but eight staff have completed the required dementia standards, and these eight are in the process of completing the training.  A continuous improvement has been awarded at criterion level in respect of team development. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. There is at least one RN and first aid trained member of staff on every shift. Interview with care givers inform the RN’s are supportive and approachable. There is a qualified diversional therapist at the facility. Interviews with staff, residents and relatives inform there are sufficient staff to meet the care needs of the residents. Staffing was appropriate for the increase from 77 PG beds to 83. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Care plans and notes are legible and where necessary signed (and dated) by a registered nurse. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration and are legible, dated and signed. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has a well-developed assessment process and resident’s needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service. Information gathered at admission is retained in resident’s records. Eleven relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the Code, how to access advocacy and the health practitioners code. An advocate is available and offered to family. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission. The admission agreement reviewed aligns with a) -k) of the ARC contract. Eleven out of eleven admission agreements viewed are signed. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. The yellow envelope system is used for transfers to the emergency department. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made. |
| 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. | FA | All medication is managed appropriately in line with required guidelines and legislation. The medications are stored in locked trolleys for each of the four units. Registered nurses or senior caregivers administer medications who have passed their competency administer medications.  The service uses two weekly robotic packs. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.  There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies.  Registered nurses are peer reviewed annually and caregivers are selected by the clinical manager and trained in medication administration and competency checked annually. Caregivers only administer medications in the dementia unit. Only those staff deemed competent administers medications. Competencies include a) questionnaire, b) supervised medication round and c) competency sign off.  All 'medication competent' staff are responsible for medication administration in all areas. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. There are no residents self-administering at Rossendale.  Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. All 20 medication charts reviewed have PRN medications prescribed with an individualised indication for use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The national menus have been audited and approved by an external dietitian. The service employs three cooks and five kitchen hands. All meals are prepared on site from one central kitchen. All of the kitchen staff have completed food safety certificates. The service has a large workable kitchen that contains storage cupboards, freezer, domestic fridge, chillers and commercial ovens. There is a preparation area and receiving area. Kitchen fridge, food, dishwasher and freezer temperatures are monitored and documented daily. Resident annual satisfaction survey includes food services and there is also a post admission survey conducted after six weeks. 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 cook that was interviewed. Special diets are noted in the kitchen out of view. Special diets being catered for include soft diets, high calorie meals, pureed meals and diabetic diets. 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. Relatives interviewed were complimentary of the food provided. Observation of meal time (lunch) evidenced staff assisting residents as required. There is evidence that there is additional nutritious snacks available over 24 hours. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Rossendale uses the Bupa assessment booklets and lifestyle templates for all residents. The assessment booklet provides in-depth assessment tools including; falls, Braden pressure area, skin, mini nutritional, continence, pain, cultural assessment and dependency and activities assessments.  Additional risk assessment tools include behaviour, restraint and wound assessments as applicable. Risk assessments are completed on admission and reviewed six monthly as part of the support plan review. A resident needs data sheet is developed on admission.  The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information. Needs outcomes and goals of consumers are identified |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health.  The long-term care plan is completed within three weeks in resident files sampled. There is a long term lifestyle care plan that includes; a) map of life, my day my way, b) socialising and activities, c) medication needs, d) personal cares, e) food and fluids, f) safety, mobility and risk, g) rest and sleep, h)communication, i) spiritual values, belief and culture, j) dementia and k) activities. Lifestyle care plans demonstrate service integration and identified that the resident/family/whanau have the opportunity to be involved in the care planning process.  Long term residents' care plans reviewed on the day of the audit provide evidence of individualised support with detailed interventions. Family members interviewed confirm care delivery and support by staff is consistent with their expectations.  Short term care plans are in use for changes in health status. Short term care plans sighted in resident files were for eye infections, bruising, skin tears, pain, and cellulitis and weight loss. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse practitioner consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, GP visits and appointments. Discussions with families are documented on the family contact form in the resident file.  Caregivers and RNs interviewed state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists, scales, shower chairs and trolleys, walking frames, wheelchairs, lazy boy chairs on wheels and gloves, masks and aprons.  Adequate dressing supplies are available. Wound management policies and procedures are in place and weighs are recorded at least monthly.  Wound assessment, wound management and evaluation forms are in place for 18 residents with skin tears, one chronic skin cancer lesion, one suprapubic catheter site, one chronic surgical wound and a skin graft wound that was present on admission. There are two sacral pressure areas that are grade one, one friction blister that results from a repetitive behaviour. Seven pressure sites prone to breakdown are monitored every three days and protected as a preventative measure. Chronic wounds are linked to the care plan. Photos are taken of chronic and non-healing wounds. The GP is notified of any non-healing wounds as evidenced in the GP notes and chronic wounds are reviewed at the three monthly medical review. All wounds have evidence of management within set timeframes.  Continence products are available and resident files include and management a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. The clinical manager (interviewed) described the referral process should they require assistance from a wound specialist, continence nurse, dietitian, speech language therapist, diabetes nurse or other allied health or nursing specialists.  There are a number of monitoring forms available for use that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, blood sugar monitoring, bowel records, continence diary, restraint monitoring and neurological observations. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one diversional therapist (DT), one activities co-ordinator and two activities assistants who all work 0800-1600. The programme is provided in all four units. The programme is developed to cover seven days a week in the hospital and Monday to Friday in all other units with activities staff rotating shifts over weekends to ensure there are two activities team members on every day. On the day of audit residents in all areas were observed being actively involved with a variety of activities including Christmas parties. The programme is developed monthly and displayed in large print on notice boards; a weekly plan is also displayed.  The programme includes networking within the community with 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 of 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 are a wide range of activities offered that reflect the resident needs in the two psychogeriatric units, the high dependency unit and the dementia unit. Participation is voluntary and one on one activity time is provided for residents who choose not participate in activities.  Family are invited to attend the resident meetings chaired by the manager. This meeting provides an opportunity for feedback and suggestions on the programme, outings and entertainment. Relatives interviewed are happy with the choice and variety activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans are evaluated by the registered nurse six monthly or when changes to care occur as sighted in eight long term resident files sampled. Two residents have not been at the service long enough for a review. Short term care plans for short term needs are evaluated and either resolved or added to the long term care plan as an on-going problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to dietitian, speech language therapist, needs assessor, mental health services for the older person, geriatrician and hospital specialists. There was evidence of where a resident’s condition had changed and the resident was reassessed for a higher level of care from rest home to hospital level of care. Discussion with the clinical manager identified that the service has access to GPs, ambulance/ emergency services, allied health, dietitian, physiotherapy, continence and wound specialists. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is a chemical/substance safety policy. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer’s labels and stored in locked areas in all services. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. The household manager is a health and safety representative and has attended health and safety training and chemical safety training. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness which expires on 1 December 2015. The building has two levels with all resident units downstairs and offices upstairs. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a maintenance person employed and another casual person available on call if required. Repairs and maintenance requests are entered into a log book that is checked daily and signed off as repairs are addressed (sighted). There is a 52 week planned maintenance programme in place. Hot water temperature is monitored weekly in resident areas and are within the acceptable range. Air temperatures in the main lounge are monitored. Preferred contractors have had a site induction completed. All medical equipment is due for recalibration in November 2015.  The living areas and bedrooms have vinyl surfaces as do bathrooms/toilets and kitchen areas. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents are observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.  The following equipment is available, electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists (checked November 2014), wheel-on scale, transferring equipment, walking frames, shower chairs and trolleys, wheelchairs, lazy boy chairs on wheels and gloves, masks and aprons.  This audit included verifying six previous dementia level beds that are now part of the hospital ( PG) unit. A secure door has been moved and the rooms are now totally part of the hospital (PG) unit. The rooms are appropriate size to manage the use of mobility equipment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms have a hand basin. There are adequate communal toilets/showers available, caregiver’s state there is always one available when required. There is appropriate signage with easy clean flooring and fixtures. Privacy locks indicate whether the toilet/shower is vacant or in use. There are communal toilets near the lounge, dining and activity areas. Eleven relatives interviewed report that they are happy that privacy is maintained, including in shared two resident bedrooms. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The hospital bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment including hoists to safely deliver care. In the hospital unit there are 16 shared rooms. Six caregivers (interviewed) report that rooms have sufficient space to allow cares to take place. The doors are wide enough for ambulance trolley access. Residents are encouraged to personalise their bedrooms as sighted. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a spacious central lounge and dining room in all units with each having a quiet/whanau room. Smaller lounges are available for small group or individual activities or for visitors. Tea and coffee making facilities are available. All communal areas are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this. Hallways are wide and enable residents to wander safely within their unit. The dining room and lounges accommodate specialised lounge chairs and space is arranged to allow both individual and group activities to occur. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All linen and personal clothing is laundered on site. There are two dedicated laundry staff daily. The laundry is well equipped with a defined dirty and clean area and entry and exit doors. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles. Chemicals are stored safely and the laundry is locked after hours. Laundry staff have attended infection control in-service and chemical safety training. Laundry cleaning schedules are maintained. There is a laundry schedule for the laundering of hoist slings.  Cleaning trolleys are well equipped and stored in locked areas when not in use. Cleaning schedules are maintained. Cleaners have attended chemical safety.  Personal protective equipment is available in the laundry, cleaning and sluice room. Staff are observed to be wearing appropriate protective wear. Eleven relatives interviewed are happy with the laundry and cleaning services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate training, information, and equipment for responding to emergencies is provided. Fire evacuations are held six monthly and the last drill was 5 December 2014. There is staff across 24/7 with a current first aid certificate. There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage area outside; this includes an up to date register of all residents’ details. There is an approved evacuation plan. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. The facility has civil defence kits. Hoists have battery backup. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal rooms and bedrooms are well ventilated and light. Eleven relatives interviewed stated the temperature of the facility is comfortable. There is plenty of natural light in resident’s rooms, along corridors and in communal areas. The facility is clean and well maintained. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme is determined by the organisation and is reviewed annually. The programme is appropriate for the size and complexity of the service. The infection control officer at Rossendale is a registered nurse and there is a job description outlining responsibilities for the role. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | At Rossendale, the infection control committee is made up of a cross section of staff. The committee meet monthly to discuss infection rates, education and internal audit outcomes. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual includes comprehensive policies and guidelines that comply with accepted good practice. Guiding policies are available for all service area including the kitchen, laundry and housekeeping services. External expertise can be accessed as required, to assist in the development of policies. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control officer is responsible for coordinating and delivering training to staff. This includes the training delivered as part of the orientation programme for new staff. The infection control officer has completed a post graduate certificate in infection control and has maintained competence by attending a day course at the district health board this year. Resident education occurs as able during daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a surveillance programme that is suitable to the size and complexity of the service. The infection control officer coordinates the surveillance programme including collation and aggregation of monthly infection rates. Corrective action plans are seen to have been developed and implemented when infection rates exceed the expected targets. The surveillance of infection data assists in evaluating compliance with infection control practices. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a regional restraint group at an organisation level that reviews restraint practices and also monthly restraint 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 twenty five restraints and two enablers in use. Of the 25 restraints 17 are lap belts and 10 bedrails with two residents utilising both. Of the lap belt restraints 14 are used for occasional emergency use only. The two enablers are both lap belts for residents who mobilise independently in wheelchairs and are able to take these off when they choose. The files reviewed included a comprehensive enabler assessment that covered alternatives and least restrictive options. A register for each restraint is completed that includes a three-monthly evaluation.  The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | Only RNs that that have completed a restraint competency assessment are permitted to apply restraints. All staff restraint competency assessments have been completed.  Interview with the restraint coordinator (clinical manager) and review of his signed job description identifies his understanding of the role. He has been in the role since February 2014 and co-ordinates education and competency assessment for staff. All staff in the facility have to pass restraint competency annually.  Restraint is used for the minimum time and this is evidenced on monitoring forms. As soon as a resident is settled the restraint is removed. Lap belts are monitored hourly and bedrails two hourly. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau.  Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety.  On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Restraint files were reviewed. The file included a completed assessment that considered those items listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails and lap belts).  The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe.  Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed monthly during the facility restraint meetings and also as part of the three-monthly restraint reviews and six monthly multi-disciplinary meetings and include family/whanau input. Any restraint incidents/adverse events are discussed at this meeting and corrective actions are initiated. The restraint coordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.  The resident file refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plans reviewed of residents with restraint and/or enabler identified observations and monitoring as per their monitoring schedules.  A restraint register is in place providing an auditable record of restraint use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for the resident on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of files of the residents using a bedrail identified that the evaluations are up-to-date and have reviewed (but not limited to); whether the desired outcome was achieved, whether the restraint was the least restrictive option and the impact of the use of restraint. Restraint is evaluated on a formal basis monthly at the facility restraint meeting and six monthly by the regional restraint team. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings.  The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. All staff at Rossendale, including administration and reception staff must pass restraint competency.  Monitoring of lap belts is undertaken hourly and bed rails two hourly. Monitoring forms were reviewed and are fully completed. Information on restraint and monitoring forms for current restraint are on bulletin boards, this is read out and discussed at every shift handover. RNs at Rossendale are the only staff permitted to apply restraint. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Bupa has a robust quality and risk management framework that is being implemented at Rossendale. The framework ensures services adhere to the health & disability services standards. There are required actions being implemented at Rossendale when outcomes do not meet targets. Corrective action plans are implemented closed out and staff are involved in quality initiatives.  External training is supported, with evidence of attendance in staff files reviewed, verified through staff interview. ‘Tool box’ sessions, which are focused discussions with staff following for example a particular incident, are also seen to be provided regularly at Rossendale.  Bupa has a strong focus on clinical benchmarking, both nationally and internationally.  Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). Of the 97 care staff at Rossendale, all have achieved bronze, 37 silver and 35 gold. | Bupa has robust quality and risk framework that is being implemented at Rossendale. The framework includes standardised policies; an education programme including core competencies for different staff groups; an internal audit and corrective action planning process; benchmarking against similar services types; centralised management of complaints and internal investigation following category one incidents; and surveys (resident/relative and staff). There is a prescribed meeting schedule for services that is also seen to be implemented at Rossendale. The following briefly outlines the processes in place at Rossendale:  The standardised policies (and associated forms) are being implemented at Rossendale with staff interviewed able to describe accessing policies as required.  The annual education programme prescribed for the organisation is being implemented at Rossendale. Where attendance at a prescribed in-service is below expected either a ‘tool box’ session or additional in-service is provided. Tool box sessions are a regular part of Rossendale practice and are held in response to either an issue or a planned improvement. Examples of tool box talks include: footwear use, high dependency unit allocation, wound management, use or as required medication, oral hygiene. Bupa prescribe competency assessments for different staff types such as RN, care givers; and these are current at Rossendale. In order to ensure competency assessments remain current a spread sheet is maintained by the care home manager and clinical manager. Rossendale supports staff to attend external. From an organisational perspective, Bupa provides a bi-monthly clinical newsletter called Bupa Nurse providing forum to explore clinical issues and updates with all qualified nurses in the company and the Bupa geriatrician provides newsletters to GPs.  Bupa prescribe an internal audit programme that again is being implemented at Rossendale. Where an internal audit result in less than 100% a corrective action plan has consistently been developed and closed out. Internal audits are delegated to various staff to encourage participation in a quality improvement programme. Clinical file review is part of the audit programme and interview with staff confirm they are involved in corrective actions when improvements are required.  Services are benchmarked by service type, with Rossendale being benchmarked against psychogeriatric and dementia care. Of particular note was an email from head office (September 2014) asking Rossendale to comment on the significant reduction in staff incidents related to resident behaviour from 46 in 2013 to 9 in 2014 (to September). It is noted this has reduced over the last four years from 79 reported incidents in 2010. Corrective action plans are developed when rates exceed expectation, of note are the two focus groups in process at the time of audit – falls and behaviour (refer 1.2.3.6).  Meetings are held regularly and minutes reviewed include discussion about key aspects of care delivery and emerging trends resulting from benchmarking. Data is graphed and available in the staff room. Corrective action planning results where trends are above a target, and there is evidence that a reduction in resident incidents results (also refer 1.2.3.6). Outstanding matters are seen to have been followed through to the next meeting.  At Rossendale relative meetings are held two monthly and meeting minutes include trending data and complaints; and also initiatives that underway. Minutes demonstrate matters arising are discussed at the following meeting until resolved. Annual relative surveys are undertaken an Rossendale and there has been an increase in overall satisfaction with the service from 83% in 2013 to 89% in 2014.  Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). Of the 97 care staff at Rossendale, all have achieved bronze, 37 silver and 35 gold.  Bupa undertake an annual staff survey – Global People Survey (GPS). Comparison between the 2013 and 2014 results indicate staff are happy with their work environment and are well supported by the care home manager and clinical manager. One example is: ‘I am encouraged to develop new and better ways of serving and caring for customers’ rated 96% in 2013 and 98% in 2014. |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Bupa Rossendale provides hospital (psychogeriatric) and rest home (dementia) care for up to 100 residents. The facility is divided into four units. There is a 50 bed hospital (psychogeriatric) unit, a 23 bed psychogeriatric unit, a 10 bed high dependency unit and a 17 bed dementia unit. On the day of audit there were 44 residents in the hospital unit, 23 in the psychogeriatric unit, 10 in the high dependency unit and 17 in the dementia unit. Bupa has an overall vision that is "taking care of the lives in our hands". There are six key values that are displayed. There is an organisational business plan and risk management plan, and each facility then develops quality goals for the year. Rossendale has four quality goals focused on reducing the rate of incidents around the following clinical indicators: resident behaviours, skin tears, falls ad pressure areas. | Bupa has robust quality and risk management systems implemented across its facilities including Rossendale. The quality system includes an organisational business and risk management plan, with each service developing specific quality goals for the year. Rossendale has four quality goals for 2014: reduce resident behaviours by 25%, reduce falls, skin tears and pressure areas by 10%. Progress towards goals are reported are through the various meetings at service level and up through the operations manager. Two focus groups were established to progress goals – falls and behaviour. There are monthly meeting minutes where all incidents are discussed and strategies put in place to mitigate ongoing risk. The clinical indicator data shows the effectiveness of these groups, for example falls in the dementia unit in February totalled nine and in November two; in the hospital areas there were 34 falls in February and 22 in November. The behaviour focus group showed particularly sound results with a reduction in the hospital area from 27 incidents in February to three in November. The goals at Rossendale are linked to the benchmarking programme. In addition to the work being carried out through the focus groups, monthly benchmarking data is available to the service and corrective action plans implemented if an indicator exceeds the expected rate.  The care home manager provides a weekly report to the operations manager. The operations manager visits regularly and reports to the general manager care homes. The managers in the region meet two monthly and teleconference weekly. A forum is held every six months (with national conference including all the Bupa managers). |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Quality improvement activity at Rossendale is guided by the Bupa quality and risk programme. To this end the facility has identified four quality goals for the 2014 year. Two of these have been carried over from 2013, indicating a commitment to meeting goals rather than setting new ones annually. The four quality goals link to resident outcomes and the clinical indicator programme and are as follows:  a) Reduce incidents resulting from resident behaviour by 10%  b) Reduce skin tears by 10%  c) Reduce falls by 10%  d) Reduce (acquired) pressure injuries by 25%  In addition to targeted goals the service develops corrective action plans when clinical indicator data exceeds the target prescribed by the organisation. Measurable quality improvements are also documented to demonstrate progress for the service. The following will focus on the four quality goals for 2014 that demonstrate the facility is proactive in using the quality improvement process to improve outcomes for residents. All progress is seen to have been reported through the various meetings and interview with staff demonstrated an awareness of progress. | The four quality goals link to resident outcomes and the clinical indicator programme and are as follows:  a) Reduce incidents resulting from resident behaviour by 10%. The goal was established at the beginning of 2014. Review of the clinical indicator data showed 27 incidents in the hospital and three in the dementia unit. A behaviour focus group was set up and minutes sighted for the monthly meetings. The meeting focused on individual resident review and suggested changes in response to trending data. Clinical indicator data is discussed at all meetings changes to the environment implemented. Month by month data shows a significant drop in reported, with the exception of April (25 for the month). As at the end of November there are three reported incidents in the hospital and one in the dementia unit. An email from head office was sighted (September) noting the marked reduction in incidents. This achievement is reflected by the KPI report, where the residents’ behaviours are under benchmarking for the last 6 months.  b) Reduce skin tears by 10%. While a focus group was not established for this quality goal, a similar process was implemented. In February there were 38 reported skin tears in the hospital and four in the dementia unit. In November there were 23 in the hospital and one in the dementia unit. For every month the service exceeded the target a corrective action was seen to have been developed and closed out. There is evidence of tool box talks including manual handling, wound care, challenging behaviour. It is noted there were three months that the service did not exceed target, and the rate of skin tears in the dementia unit was under five for the period February to November.  c) Reduce falls by 10%. As with the behaviour goal a focus group was established with monthly meeting minutes sighted. At the beginning of the year the service reported nine falls in the dementia unit and 34 in the hospital. Up to and including May the service continued to exceed the expected target and the corrective action planning process was put into place. From June to November the service has been under the target, the falls focus group continues. Rate in November was 22 in the hospital and two in the dementia unit.  d) Reduce (acquired) pressure injuries by 25%. Across the 2014 data the service has consistently shown under seven acquired pressure injuries per month. As would be expected these were noted in hospital level residents. There is a high level of reporting, with incident forms noted where a reddening is seen (as opposed to broken skin). In February there were five reported injuries and nil reported for September, there is an average of 3 reported injuries per month. The low rate has been achieved by upgrading equipment cushions/mattresses and on-going training for staff. |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | CI | There are policies including recruitment, selection, orientation and staff training and development. Eleven staff files were reviewed and all had personal file checklists. Performance appraisals were current in all files reviewed. Team development has been a particular focus of the care home manager and the improvements are now becoming intrinsic to the service functioning. | The care home manager has been focused on creating a culture of mutual respect, noting this has been a four year journey. Interviews with staff demonstrated an awareness of the change including the fact underperforming staff no longer work at the facility, and a noticeable shift toward a resident focused model of care has developed. The improvements achieved across the last four years have been developed into a poster and were recently presented to staff – the poster remains in the staff room.  As part of the Bupa B-fit programme, Rossendale had a Baton relay competition, weight loss programme and entered a volleyball team into a local competition - Bupa Thunder strikes. There is evidence of accolades from staff who participated in the team event. External education was provided for staff on request including: wellbeing, spirituality, nutrition and fitness. There were regular celebrations, like cultural days, Christmas parties, and a Halloween party where staff could bring their families.  Staff involvement in improvements was encouraged via regular meetings with lunch provided. Discussion included how to improve on complaints (2013 total 22; 2014 to date 10), learning and achievements.  Education has been a key focus for the service with staff actively being encouraged to attend and complete external training programmes – for example one of the activities co-ordinators completed her Dementia Unit Standards, Core Competencies and Diversional Therapy qualification in 2013-2014; several nurses attended development programmes in Waikato DHB on Gerontology, Leadership, Delirium and other local trainings, one staff member has been supported to completed her enrolled nurse training. Interviews with staff confirmed the service supports attendance at external training.  The care home manager has been pivotal in developing the current team and philosophy of care within Rossendale. This is seen in staff satisfaction results where manager effectiveness score was rated at 97% and staff engagement 96%. Other aspects of the survey included: ‘My manager has invested time and effort in my growth’ – 97% (up 5% from 2013); ‘My manager regularly talks to me about my performance’ – 96% (up 2% from 2013); ‘I am encouraged to develop new and better ways of serving and caring for customers’ – 98% (up 2% from 2013).  Rossendale has a high uptake of the personal best programme run through Bupa with 100% of care staff having attained bronze, 38% silver and 36% gold.  Staff retention was reportedly 85% for 2013; at the time of audit the 2014 results were not known however interview with the care home manager informs a stable workforce.  This work has had a positive impact on reported satisfaction from relatives where overall satisfaction increased by 7% from 83% in 2013 to 89% 2014. |

End of the report.