# Bupa Care Services NZ Limited - Riverside Care Home and Hospital

## Introduction

This report records the results of a Surveillance 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:** Riverside Care Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 5 February 2014 End date: 5 February 2014

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 59

# 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** |
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|  | 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

Riverside Care Home and Hospital is part of the Bupa group. The service is certified to provide rest home, hospital and dementia level care for up to 65 residents. On the day of the audit there were 59 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management. The nurse manager is appropriately qualified and experienced. Feedback from residents and relatives was positive.

Three of the four shortfalls from the previous certification audit have been addressed. These are around timeliness of care plans, wound management and medication management. Nine of the ten shortfalls from the previous partial provisional audit have been addressed. The service has undergone a renovation project and a number of shortfalls relating to the building have been addressed. Improvement continues to be required around building renovations.  
Improvements required from this audit are related to meeting minutes, corrective action planning, incident follow up, staff training, an aspect of medication documentation and food storage.

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

Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family are well informed including of changes in resident’s health. The care home manager and clinical manager have an open door policy.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Riverside has an established 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 resident/relative meetings. Riverside is benchmarked against other Bupa facilities. Incidents are documented and there is immediate follow up from a registered nurse. 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 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. Staffing levels are monitored closely with staff and having input into rostering.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these have been reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.   
The activities programme is facilitated by an activities officer. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis.  
All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. The dementia unit has been completed and made secure.

## 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 aligns with the definition in the standards. There are four restraints and one enabler being used. Enabler use is voluntary. Staff are trained in restraint minimisation and challenging behaviour.

## 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 co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

## 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** | 0 | 12 | 0 | 6 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 7 | 0 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The number of complaints received each month is reported monthly to care services via the facility benchmarking spread sheet'. There is a complaints flowchart.  D13.3h. The complaints procedure is provided to resident/relatives at entry and prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow up letters and resolution demonstrates that complaints are well managed. .  Discussion with seven residents (four hospital and three rest home) and seven relatives (three dementia, three hospital and one rest home) confirmed they were provided with information on complaints and complaints forms. 2014 and 2015 to date complaints were reviewed. All were well documented including investigation, follow up letter and resolution. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.  Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident.  Incident forms reviewed identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files. D16.4b All relatives interviewed stated that they are always informed when their family members health status changes.  There is an interpreter policy and contact details of interpreters.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.  D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  D11.3 The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Riverside has set specific quality goals for 2015.  Riverside provides rest home, hospital and dementia level care for up to 65 residents. There were 17 residents in the dementia unit, 16 hospital level residents and 26 rest home level residents on the day of the audit.  The care home manager has been at the service since October 2012 and has many years of aged care management experience. She is supported by a clinical manager who has been in the service since June 2014. The new manager has many years’ experience in aged care including dementia care and management. Managers and clinical managers attend annual organisational forums and regional forums six monthly. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Riverside has an established quality and risk management system.  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. Policies are current and staff are informed of updates and changes. Key components of the quality management system link to the monthly quality, health and safety and infection control meetings, registered nurses meetings and staff meetings at Riverside. Meeting minutes do not always reflect discussion of quality data trend analysis. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation.   There are monthly accident/incident and infection benchmarking reports are provided to Riverside for rest home, hospital and dementia level care. Internal audits are completed according to the Bupa schedule. Corrective action plans are not always developed when service shortfalls are identified.   The health and safety committee meets monthly and there is a current hazard register for Riverside.    D19.3: There is a comprehensive hazard management, health and safety and risk management programme in place. There are facility goals around health and safety.   D19.2g Falls prevention strategies are in place. |
| 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. | PA Low | D19.3c: The service collects incident and accident data.  D19.3b; The service documents and analyses incidents/accidents. Individual incident reports are completed for each incident/accident with immediate action noted. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Incident reports are not always assessed for a means to prevent recurrence before being signed off.  Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health were informed of two recent outbreaks on the day of the outbreak. |
| 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 | A register of practising certificates is maintained.  Seven staff files reviewed included up to date performance appraisals and documentation.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice including around caring for those with dementia. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. Completed orientation booklets are on staff files. Staff interviewed (three caregivers – one from each unit, one registered nurse from the dementia unit and two activities coordinators) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. A training session on dementia care was provided for staff prior to the opening of the dementia unit. This is an improvement since the previous audit.   There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. Attendance at in service education sessions is low. Registered nurses (RN’s) are provided with suitable training. A competency programme is in place with different requirements according to work type.   E4.5f There are nine caregivers that work in the dementia unit. Two caregivers who have been working in the dementia until longer than six months are not yet enrolled to complete the required dementia standards. |
| 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.  There is a registered nurse on duty 24 hours per day, with two on duty from 0700 to 2300 hours. Additionally the care home manager and clinical manger are registered nurses and work 40 hours per week. Interviews relatives and residents all confirmed that staffing numbers were good. Caregivers interviewed stated that they have staffing levels were good. |
| 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 | Bupa has comprehensive medication policies in place. Medication storage and administration follow safe guidelines. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on admission. All staff administering medication have completed an annual medication competency.  Sixteen medication charts were reviewed (four rest home, six hospital level and six dementia care). They were legible and meet legislative guidelines. Ten of the 16 medication charts sampled have photographic identification. Signing on administration was up to date, including as required medications (PRN). All PRN medications had indication for use identified on the medication chart. All medication charts identified any allergies. Sixteen medication charts reviewed had written evidence of the GP three monthly review, or more as conditions changed, all had been signed and dated. All medications prescribed to be administered regularly were signed as being administered regularly. Weekly medication checks documented. These are improvements since the previous audit. |
| 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. | PA Low | The national menus have been audited and approved by an external dietitian. The service employs a kitchen manager and kitchen assistants. Fridge temperatures are monitored and documented daily in the kitchen. All food containers are labelled in kitchen but not in the small rest home and dementia care fridges. Meals are prepared in the kitchen and delivered to the rest home, hospital and dementia care dining rooms. There are nutritional assessments and management policy and a weight management policy. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets are catered for. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the nurse manager initiates a review and if required, GP or specialist consultation.  The caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. All staff report that there are always adequate continence supplies and dressing supplies. Residents and families interviewed were complimentary of care received at the facility. The care being provided is consistent with the needs of residents; this is evidenced by discussions with four caregivers, three families interviewed, and clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans are in place for seven residents. There is one pressure area identified in the service. All wound assessments have completed short term care plans describing appropriate interventions. All wounds have been reviewed in the timeframes. |
| 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 are two activity co-ordinators who works in both the rest home and dementia unit who work from 0900-1500 providing seven days a week cover. The dementia care activities co-ordinator interviewed had completed a dementia course.  There is a full and varied activities programme in place which is appropriate to the level of participation from residents’. On the day of audit residents in both areas were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print in communal areas and resident bedrooms. Residents and families interviewed voiced their satisfaction of the activities programme and felt that recreational needs were being met.  Residents have an activities assessment completed over the first few weeks. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.  Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans are reviewed and evaluated by an RN at least six monthly, or as changes to care occur as sighted in all care plans sampled. This is an improvement since the previous audit. ARC: D16.3c: All initial care plans are evaluated by the RN within three weeks of admission. There is documentation evidence of family and/or resident involvement at these evaluations.  Documentation on clinical notes evidence review by the GP at least three monthly. There are short term care plans to focus on acute and short-term issues. This is an improvement since the previous audit. From the sample group of residents' notes the short-term care plans were overall well used and comprehensive. Examples of short-term plan use included; infections, wounds and weight loss. |
| 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 | The previous audit identified that the sluice room was not yet complete or locked. This has been completed and all chemicals are stored securely. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | Reactive and preventative maintenance occurs. The building holds a current warrant of fitness. Since the previous audit the facility has undergone significant refurbishment with one wing still to be completed. The dementia unit including the lounge/dining area and kitchenette has been completed. Water temperatures are checked monthly throughout the facility. These are improvements since the previous audit. Improvement continues to be required around two bathrooms in the wing yet to be renovated.  The external areas are well maintained and gardens are attractive. E3.4.c: There is a safe and secure outside area that is easy to access off the dementia unit. The outside area for residents in the dementia unit is well designed and appropriate for residents who like to walk about. This is an improvement since the previous audit. E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities. ARC D15.3: Suitable equipment is available for rest home, hospital and dementia level care. E3.3e: There are quiet, low stimulus areas that provide privacy when required. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The previous audit identified that the call bell system in the dementia unit had yet to be activated. The system is now fully functioning and staff are alerted when required. The previous audit also identified that the keypad locks had not been installed at the two entrance doors and the doors off five resident rooms have not yet been adjusted to ensure they cannot be used to exit the building. These have been addressed and the dementia unit is now secure. |
| 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 | The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Infection control data is collated monthly but not always reported at the quality, RN and staff meetings (link 1.2.3.6). The infection control programme is linked with the quality management programme.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There are four residents with restraint and one with an enabler. Review of the resident with the enabler’s file shows that enabler use is voluntary. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There are monthly quality, health and safety and infection control meetings, registered nurses meetings and staff meetings. Minutes are kept using an agenda template for all meetings. The numbers of incidents according to category and infections according to category are presented at all meetings. Staff interviewed report being informed of internal audit results. | Minutes of quality, health and safety and infection control meetings, registered nurses meetings and staff meetings do not consistently document outcomes of internal audits or discussion around analysis of accidents and incidents or infections. | Ensure that all service providers have the results of quality improvement data analysis communicated to them.  90 days |
| Criterion 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. | PA Low | The service benchmarks with other Bupa facilities for rest home, hospital and dementia quality days. Monthly benchmarking outcomes are provided to the service. Internal audits are undertaken and there is a corrective action format available which has been used for 20 of 36 audits where shortfalls were identified. | Corrective action plans have not been developed for 16 of 36 internal audits in 2014 and 2015 to date where shortfalls have been identified. | Ensure corrective action plans are developed when service shortfalls are identified.  90 days |
| Criterion 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. | PA Low | D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events. Individual incident reports are completed for each incident/accident with an area to document immediate action which is completed by the registered nurse on duty, and any follow up action required. Incident data is linked to the organisation's benchmarking programme and this is used for comparative purposes. | Seven of nine incident forms sampled had been signed off as complete with no documented analysis of the incident or interventions to prevent recurrence. | Ensure all incidents are analysed and opportunities to prevent recurrence identified and implemented.  90 days |
| 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 | In-service training has been provided around all required subjects including rights, abuse and neglect, cultural safety, wound management, falls prevention and nutrition. There are nine caregivers who work in the dementia unit. Three have completed the required dementia standards and four who have worked at the service less than one year are in the process of completing. | (i) Attendance at staff training is low. For example: continence (six of 50 staff, pressure area prevention (five of 50 staff), Code of Rights (10 of 50 staff) and cultural awareness (12 of 50 staff). (ii) Two of nine caregivers who work in the dementia unit have worked there longer than six months and are not yet enrolled to complete the required dementia standards. | (i) Ensure all staff receive training in required areas. (ii) Ensure all staff who work in the dementia unit commence the required dementia standards within six months of starting.  90 days |
| Criterion 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. | PA Low | All ten medication charts sampled have been completed and reviewed three monthly by the GP. They are clear and legible and the GP signs and dates when medications are discontinued. All medication charts document allergies or nil known. As required medications document the indication for use and how often the medication can be used. | Six medication charts reviewed did not have a photograph identifying the resident. | Ensure all resident medication charts have an up to date photograph of the resident for assisting with identification.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Bupa Riverside have policies and procedures regarding the safe storage of food. There are small food fridges situated in the dementia care unit, hospital and dining room. All food stored in fridges in the kitchen have daily temperature recordings monitored and are dated and labelled. | There were containers of unlabelled and undated food in the small food fridges in the hospital and dementia care unit. | Ensure all food complies with safe storage policies and include labels identifying the food and date.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | There is a maintenance person who is employed part time. Since the previous audit the dementia unit has been completed and all but one wing have had the renovations completed. There is a current building warrant of fitness that expires on 15 December 2015. | The temporary staff and visitor toilet and the hospital toilet one have damaged paint on wall surfaces and inadequate floor coverings. | Complete the planned renovations to ensure that all toilets can be cleaned to the required infection control standards.  180 days |

# 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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End of the report.