

Bupa Care Services NZ Limited - Fergusson Rest Home & 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](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Fergusson Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 March 2015 End date: 10 March 2015
Proposed changes to current services (if any):	Click here to enter text
Total beds occupied across all premises included in the audit on the first day of the audit:	108

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

Indicator	Description	Definition
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Fergusson 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 112 residents. On the day of the audit there were 108 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 care home manager is appropriately qualified and experienced. Feedback from residents and relatives is positive.

The service continues to exceed the required standard around good practice, complaints management, governance and strategic goals, the quality management system, restraint minimisation and infection control surveillance.

Consumer rights

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.

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. Complaints processes are implemented and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

Organisational management

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.

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

Fergusson 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. Fergusson 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

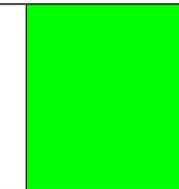
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Resident records reviewed provided 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 are reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans were reviewed six monthly, or when there were changes in health status. Medication policies and procedures are in place to guide practice. Education and competencies are completed by all staff responsible for administration of medicines.

The activities programme is facilitated by an activities co-ordinator and two activity assistants. 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.

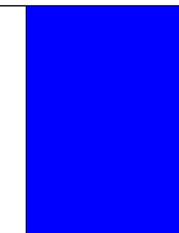
All food is cooked on site by the in house by the kitchen manager. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.
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There is a Bupa restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There are seven restraints and four enablers being used. Enabler use is voluntary. Staff are trained in restraint minimisation and challenging behaviour.

Infection prevention and control

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.

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

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.

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	7	11	0	0	0	0	0
Criteria	9	32	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>CI</p>	<p>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 residents and relatives 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.</p> <p>The service continues to exceed the standard around implementing learning's from complaints.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate</p>	<p>CI</p>	<p>Bupa Fergusson continues to exceed the required standard around good practice. Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. Four</p>

<p>standard.</p>		<p>general practitioners (GP) each visit the facility weekly and one twice a week. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the District Health Board which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site, four hours per week. There is a regular in-service education and training programme for staff. A podiatrist visits weekly. The service has links with the local community and encourages residents to remain independent.</p> <p>The GP interviewed spoke positively about the level of care that is being provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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.</p> <p>D16.4b: All relatives interviewed stated that they are always informed when their family members health status changes.</p> <p>There is an interpreter policy and contact details of interpreters.</p> <p>D12.: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>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.</p> <p>'D11.3: The information pack is available in large print and advised that this can be read to residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>CI</p>	<p>Fergusson set specific quality goals for 2015 and evaluated their 2014 goals.</p> <p>Fergusson provides rest home, hospital and dementia level care for up to 112 residents. There were 14 residents in the dementia unit, 41 hospital level residents and 53 rest home level residents on the day of the audit.</p>

		<p>The care home manager has been in the role for 10 years. She is supported by a clinical manager who has been in the service since for six years, three and $\frac{3}{4}$ in the current role. Managers and clinical managers attend annual organisational forums and regional forums six monthly.</p> <p>Fergusson continues to exceed the standard around governance.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	CI	<p>Fergusson has an established quality and risk management system which continues to exceed the required standard.</p> <p>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.</p> <p>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 Fergusson. Meeting minutes reflect discussion of quality data trend analysis. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality management coordinator provide a coordinated process between service level and organisation.</p> <p>There are monthly accident/incident and infection benchmarking reports are provided to Fergusson for rest home, hospital and dementia level care. Internal audits are completed according to the Bupa schedule. Corrective action plans are developed when service shortfalls are identified.</p> <p>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. The health and safety committee meets two monthly and there is a current hazard register for Fergusson.</p> <p>D19.2g: Falls prevention strategies are in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	CI	<p>D19.3c: The service collects incident and accident data.</p> <p>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 assessed for a means to prevent recurrence before being signed off.</p>

		Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service continues to exceed the standard around responses to incidents and accidents.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>A register of practising certificates is maintained. Seven staff files reviewed included up to date performance appraisals and documentation.</p> <p>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 were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>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.</p> <p>E4.5f There are 11 caregivers that work in the dementia unit. All have completed the required dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes.</p> <p>There is a registered nurse on duty 24 hours per day, with three in the hospital (including the unit coordinator) in a morning shift, two in the evening and one overnight. Additionally there is a registered nurse as unit coordinator in the rest home and a registered nurse overnight in the rest home and dementia units. Additionally the care home manager and clinical manger are registered nurses and work 40 hours per week.</p> <p>Interviews relatives and residents all confirmed that staffing numbers were good. Caregivers interviewed stated that they have staffing levels were good.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>Bupa has comprehensive medication policies in place. Medication storage and administration follow safe guidelines. Medication reconciliation is completed on</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>admission and the policy includes guidelines on checking medications on admission. All staff administering medication have completed an annual medication competency.</p> <p>Eighteen medication charts were reviewed (seven rest home, six hospital level and five dementia care). They were legible and meet legislative guidelines. Seventeen of the eighteen medication charts sampled have photographic identification. The other resident is very new to the service. 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. All medication charts reviewed had written evidence of the GP three monthly review, or more frequently 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.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The national menus have been audited and approved by an external dietitian. The service employs a kitchen manager, cooks and kitchen assistants. Fridge temperatures are monitored and documented daily. All food containers are labelled. Meals are prepared in the kitchen and delivered to the main rest home and hospital dining room and also the dementia care dining room.</p> <p>There are nutritional assessments and management policy and a weight management policy.</p> <p>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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the clinical manager or registered nurse initiates a review and if required, GP or specialist consultation.</p> <p>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.</p> <p>The care being provided is consistent with the needs of residents; this is evidenced by discussions with caregivers, families and registered nurses. There is a short-</p>

		<p>term care plan that is used for acute or short-term changes in health status. D18.3 Dressing supplies are available and a treatment room is stocked for use.</p> <p>Wound assessment and wound management plans are in place for 29 residents. All wound assessments have completed short term care plans describing appropriate interventions. All wounds have been reviewed in the timeframes.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>There is an activity co-ordinator and two activity assistants who work in the rest home, hospital and dementia unit who work providing five days a week cover. The dementia care activities co-ordinator is in the process of completing dementia papers.</p> <p>Activity staff are supported in programme development by the Bupa occupational therapist.</p> <p>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 all areas were observed being actively involved with a variety of activities. The programme is developed monthly and displayed in large print in communal areas and resident bedrooms. Residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met.</p> <p>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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>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 reviewed were evaluated by the RN within three weeks of admission. There is documentation evidence of family and/or resident involvement at these evaluations.</p> <p>Documentation on clinical notes evidence review by the GP at least three monthly.</p> <p>There are short-term care plans to focus on acute and short-term issues. From the sample group of residents' notes the short-term care plans are generally well used and comprehensive. Examples of short-term plan use included; infections, wounds and infections.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	FA	<p>Reactive and preventative maintenance occurs. The building holds a current warrant of fitness.</p>

accessible physical environment and facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<p>The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>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 and reported at the quality, qualified staff and staff meetings. The infection control programme is linked with the quality management programme.</p> <p>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.</p> <p>Fergusson continues to exceed the required standard around infection control surveillance.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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.</p> <p>There are seven residents with restraint in the hospital and four with enablers. There is a strong drive to reduce restraints and involve families/EPOA in the process. Review of restraint usage is completed in the facility and is benchmarked against the organisation. Residents' files for residents with enabler's shows that enabler use is voluntary.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	CI	<p>The service continues to exceed the standard around restraint minimisation.</p>

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.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	CI	<p>The complaints procedure (065) states 'the care home manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. 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. The number and nature (theme) of complaints received each month is reported monthly to the organisational quality and risk department via the facility benchmarking spread sheet'.</p> <p>The complaints procedure is provided to resident/relatives at entry and also prominent around the facility. 2014 and 2015 year to date complaints were reviewed and included written complaints and verbal complaints. All were well</p>	<p>Fergusson continues to exceed the required standard around response to complaints. The service has taken a pro-active response to all complaints so that staff can learn from them. The following was implemented following a complaint. An example includes the introduction of a basket in each resident's room that contains all valuable personal items such as dentures, hearing aids and glasses with a list of the contents so that staff can be immediately aware of something missing. Complaints are an agenda item in all meetings. The care home manager responds to all questions and feedback raised from residents/families at resident/relative meetings. A corrective action plan was raised following the resident/relative satisfaction survey and this was shared with residents/relatives.</p>

		documented including investigation, follow up letter and resolution.	
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Benchmarking data continues to support initiative development and there was a number at Fergusson where quality indicator corrective action plans have been established due to benchmarking being above the expected i.e.: raised KPI for increased falls in dementia unit in October 2014, this was repeated November 2014. An action plan was established which included progress and evaluation and involved toolbox talks to staff and residents. Corrective actions have been established for complaints as well and shared with staff.</p> <p>A policy and procedure review committee (group) continues to meet monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts. Fergusson has a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies.</p>	<p>Fergusson continues to implement the "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Fergusson – 81.1%of staff have attained bronze, 34.7%silver and 12.6% have achieved gold. Benchmarking results are provided and reviewed at Fergusson. Quality improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Fergusson through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. There is an education officer 15 hours a week at Fergusson. The service has introduced leadership development of qualified staff (the clinical manager attended in 2014) - education from human resources, attendance at external education and Bupa qualified nurse's education day and education session at monthly meeting. Fergusson is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. Quality improvement corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. Eg: Falls above KPI in hospital October and November 2014. Evaluation identified that several falls related to resident's toileting so a toileting schedule before and after lunch was introduced.</p> <p>Quality action forms are also established for</p>

			<p>areas that staff/management identify as requiring improvement. An example in 2014 includes coloured circles on walking frames to alert all staff if a resident requires supervision or assistance when mobilising. Toolbox talks are routinely completed that link to benchmarking indicators in each of the three areas at Fergusson. These are also utilised for 'key learning's'. An example includes a toolbox talk around showering practices and management of shared ensuites following a complaint in January 2015.</p>
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Bupa Fergusson provides hospital - medical, geriatric, rest home and dementia care for up to 112 residents. There were 53 of 53 rest home residents, 41 of 41 hospital residents and 14 of 18 residents in the dementia unit. There are no residents under the medical component of their certificate.</p> <p>Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. In 2009, Bupa introduced a person centred care focus which includes six pillars. This has been embedded in service delivery at Fergusson.</p> <p>There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Fergusson has set specific quality goals for 2015 including (but not limited to); a) increase flu vaccine intake by staff, b) increase staff attendance by 25% to compulsory education, c) increase silver personal best by 10%, and d) increase GPS around getting healthy by 20%.</p>	<p>The service continues to develop and implement quarterly quality reports on progress towards meeting the quality goals, these are forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Fergusson annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Fergusson continues to implement the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. Improvements have been noted by residents, relatives and staff. The organisation has a clinical governance group. Specific issues identified in HDC reports (learning's from other provider complaints) are also tabled at this forum. The care home manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the Director Care Homes & Rehab. Fergusson is part of the central Bupa region which includes eight</p>

		<p>The Bupa Quality and Risk team provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.</p> <p>There is an overall Bupa business plan and risk management plan.</p>	<p>facilities. The managers in the region meet four monthly, senior managers mentor and provide guidance to new managers. A forum is held every six months (with national conference including all the Bupa managers). In 2014, Bupa's global challenge was 'The Bupa baton relay.' Fergusson had 150 participants walking. The participants included staff, residents in wheelchairs, families, the village, and families of staff.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>There is a comprehensive quality and risk management process in place. The service monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, Code of rights, weight management, health and safety, accident reporting documentation, care planning and infection control.</p> <p>Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.</p> <p>Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee e.g. quality, staff, and an action plan is identified. These were comprehensively addressed in meeting minutes sited.</p> <p>There are also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Fergusson is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified.</p>	<p>There continues to be a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. Quality indicator corrective action plans have been established on a regular basis in all three areas where Fergusson is above the benchmark. i.e.: in October and November 2014 falls were high in the dementia unit as a result a CAR was established which included a breakdown of the falls by resident, area in the facility and time of day, possible contributing factors, progress and evaluation and recommendations that included (but not limited to), discussing hip protectors and non-slip footwear with families, discussing Vitamin D for those not on this and aggressive treatment of UTI's. Tool box talks for staff reinforce falls prevention practices. Falls remained below the benchmark in December and January 2015.</p>

		<p>The service is active in analysing data collected. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Fergusson is currently benchmarked in three of these areas- hospital, dementia and rest home. Quality indicators are provided to the benchmarking groups. Feedback is provided to Fergusson via graphs and benchmarking results are discussed. Corrective action plans are completed where benchmarking was above i.e.: falls above KPI in October and November 2014 in the dementia unit. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the Director Care Homes & rehab.</p>	
<p>Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>The service plans and operational structures combine to provide a comprehensive quality development and risk management system. Reports are provided to the quality meeting by key staff including; health and safety representative, infection control representative, kitchen, education, laundry, unit reports and restraint.</p> <p>Benchmarking reports are generated throughout the year to review performance over a 12 month period.</p> <p>Quality action forms are utilised at Fergusson to document actions that have improved or enhanced a current process or system or actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, for example,</p>	<p>The service continues to implement a comprehensive quality and risk management process that includes on-going evaluation and review. Monthly benchmarking occurs throughout the group. Quality action forms are utilised at Fergusson and document actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, e.g. quality meeting, resident and staff meeting. Fergusson has monthly quality meetings and includes progress to meeting their annual quality goals. The service completed regular progress reporting and implemented on-going corrective action plans to meet their 2014 goals; a) Goal - to promote personal best and ensure all new</p>

		quality meeting, and through newsletters.	staff trained within first four months and show a 15% increase in silver achieved. This goal was met by November 2014. Twenty two staff achieved silver in 2013 and 31 in November 2014 – an increase of 24%. b) Goal - to reduce facility acquired pressure areas by 20% in the hospital area. This included staff education, random staff surveys of staff understanding of interventions to reduce the risk of pressure areas, purchase of extra equipment, reviewing the turning programme and analysing any new pressure injuries. The incidence of facility acquired pressure areas reduced from 20 in November 2013 to 11 in November 2014. Feedback is regularly provided to residents/relatives through meetings and newsletters of quality goals and progress.
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated. The robust quality gathering, analysis and reporting system identifies a number of improvements to service delivery over the last year. Corrective action plans are initiated where an area of concern is identified (for example, falls, medication errors) then further analysis is completed through the quality meeting. A corrective action plan detailing what steps are being taken to address the issues is also completed.</p> <p>Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. A review of 2014</p>	<p>The robust quality gathering, analysis and reporting system identifies a number of improvements to service delivery over the last year. Corrective action plans are initiated where an area of concern is identified (for example, falls, medication errors) then further analysis is completed through the quality meeting. A corrective action plan detailing what steps are being taken to address the issues is also completed including recommendations. An example of a comprehensive plan established in the hospital for 2014 (noting both the rest home and dementia unit had plans and actions well established too) included falls above the benchmark in October, November and December 2014. As a result every fall was analysed and tool box talks were completed around timely responses to call bells. The task allocation for evening shift was altered to make</p>

		internal audits identify that corrective actions were established for all audits that did not achieve 100%. Quality indicator analysis and corrective action plans policy is a guide for staff around corrective action plans.	one staff member primarily responsible for answering bells and all statistics were displayed for staff review. There were also examples of internal audits that included further toolbox training sessions for staff including environmental hygiene – nursing in July and November 2014 and staff knowledge of Code of rights in July 2014. Quality alerts provided from head office also were shared with staff and residents(if required). These included action plans and training.
<p>Criterion 1.2.4.3</p> <p>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.</p>	CI	The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and peer review meeting reflect a discussion of benchmarking results.	The service continues to document and analyse incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. It was noted that Fergusson had rarely been above the benchmark which was an excellent achievement. Individual incident reports were completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and qualified staff meeting reflect a discussion of benchmarking results. An example in 2014 included falls in the dementia unit being above the benchmark in October and November. A detailed quality action plan was developed which resulted in a decline in falls for December 2014 and Fergusson dementia remaining below the benchmark since.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions,</p>	CI	Infection control (IC) data is collated monthly and reported to the quality and health and safety	The service continues to exceed the required standard around infection control surveillance.

<p>and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>meetings. The meetings include the monthly IC report. Infections are documented on the Infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality management programme. Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. There is a number of internal audits completed including (but not limited to) standard precautions (December 2014 100%), Food Service (July 2014 97% - corrective action plan implemented), and environmental cleanliness (November 2014 96% - corrective action plan implemented).</p>	<p>Fergusson has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC statistics are discussed at qualified staff meetings, infection control meetings and staff meetings and corrective actions are implemented when infections increase. The incident/infection - analysis tool is utilised to assist with identifying trends. An example includes the service benchmarking showing that incidents of MRSA were above the KPI for January 2014. The quality indicator corrective action plan shows a number of implemented actions around the individual residents. Additionally families were kept informed of the progress and any changes, a tool box talk was completed during staff handovers with an emphasis on hand washing and a sign (that did not breach the resident's confidentiality) was placed on the doors to alert non clinical staff. The Hutt Valley infection control team was invited to attend the service and staff training was completed early in March 2014 around this.</p>
<p>Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate</p>	<p>CI</p>	<p>There are Bupa policies around the completion of restraint assessments and monitoring. This is benchmarked with other Bupa facilities.</p>	<p>Individuals' approved restraint is reviewed at least two monthly through the clinical and quality meeting and as a multi-disciplinary review with family/EPOA involvement. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. The organisation and facility are proactive in reducing restraints. Currently there are no residents on restraints in the dementia unit or rest home. No one has been restrained in the rest home since April 2011. There are seven hospital level residents on restraint. Restraints used do not currently include bed rails but lap belts and one low/low</p>

<p>duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>			<p>bed. There are four hospital level residents currently using enablers. There is full family/EPOA consultation documented around the use of any restraint and enablers. Alternatives and risks are explored and restraint is only used as a last resort. Regular falls assessments and toileting regimes are used, as well as assessments by physiotherapists, training and staff competencies. The facility have worked hard to reduce the number of residents' on restraint and maintain this status through the two monthly meetings, handovers, on-site training/toolbox talks with care givers and registered nurses. Staff talked about the need to reduce restraints and were able to identify risks involved and the need to monitor residents'.</p>
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End of the report.