# Bupa Care Services NZ Limited - Elizabeth R Rest 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:** Elizabeth R Rest Home and Hospital

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

**Dates of audit:** Start date: 28 April 2015 End date: 29 April 2015

**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:** 37

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Bupa Elizabeth R Home and Hospital provides hospital and rest home level care for up to 37 residents. On the day of audit there were 37 residents. The service is managed by a care home manager who is an enrolled nurse and has been in the role since July 2014. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed all five findings from the previous audit in relation to incident reporting, care plan interventions and short term care plans aspects of care planning, medication documentation and training for the infection control officer.

This audit identified improvements required around aspects of the quality programme, aspects of human resources, aspects of education, medication competencies for staff, standing orders and review of restraint and enablers.

## 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. |

Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

## 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 medium or high risk and/or unattained and of low risk. |

There is a quality and risk programme that involves the resident on admission to the service. The Bupa strategic and quality plan is not being fully implemented at Bupa Elizabeth R. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place to determine staffing levels and skill mixes. Staffing levels meet contractual requirements.

## 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 medium or high risk and/or unattained and of low risk. |

Registered nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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

The building has a current warrant of fitness that expires 9 July 2015.

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

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 three restraints and three enablers 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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

## 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 | 14 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 9 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisational complaints policy is implemented at Bupa Elizabeth R. The care home manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. A feedback form was completed for each complaint recorded on the complaint register. There is a complaints register maintained that included relevant information regarding the complaint. Verbal complaints were included and actions and response documented. The number of complaints received each month is reported monthly to staff via the various meetings. There were 14 complaints during 2014 all with documented evidence of resolution. There has been two complaints to date in 2015 both fully resolved. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Feedback forms were available for residents/relatives in various places around the facility. A complaints procedure is provided to residents within the information pack at entry. The complaints procedure is provided to relatives on admission and this was confirmed through interview with four relatives. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Six residents (four rest home and two hospital) and four family members (three rest home and one hospital) interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings take place and the care home manager, clinical manager and registered nurses have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English then the interpreter services are made available. All residents were English speaking on the day of audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Elizabeth R rest home and hospital is a Bupa facility. The service provides rest home and hospital level care for up to 37 residents. There were 37 residents (32 rest home including two respite and five hospital) in the facility on the day of audit. There is a contracted physiotherapist that provides 2 hours per week, and a contracted medical centre providing general practitioner services. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Elizabeth had quality goals for 2014, however there is no evidence of review of these goals including progress towards meeting them. The service as had one quality meeting in 2015 and has set goals for 2015 including having regular meetings, increase attendance at education sessions and implement an aged care programme (# link 1.2.3.1).  The care home manager (enrolled nurse) at Elizabeth R has been in the role since July 2014 and has a background in aged care. The care home manager was on leave on the days of audit. The care home manager is supported by a clinical manager (registered nurse) who oversees clinical care. The clinical manager had been in post at the service as an RN since July 2013 and has been the clinical manager for one year. The clinical manager was present on the days of audit. The clinical manager provides peer support and supervision to the unit coordinator of the rest home (EN), registered nurses and caregivers. The management team is supported by the wider Bupa management team including a regional operations manager. The care home manager and clinical manager have maintained professional development related to managing a hospital facility. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. The Bupa regional manager was present on the days of audit. |
| 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 Moderate | Bupa Elizabeth R is not fully implementing the Bupa quality and risk management system which is designed so that key components are linked to facility operations. The systems have been in use since July 2013 when the Bupa Group purchased the facility. The quality committee has not been meeting regularly and outcomes have not been reported across the various meetings including the staff meetings and clinical meetings. Minutes reviewed for a quality meeting held in 2015 include discussion about the key components of the quality programme, however minutes have not been held regularly. Resident and relative meetings are held three monthly and issues raised are seen to have been followed through, however annual resident survey results have not been reported back to residents.  Policy review is coordinated by Bupa head office. A policy and procedure review committee meets monthly to discuss the policies identified for the next two policy rollouts. Facility staff have the opportunity to provide feedback during the review process. Policy documents have been developed in line with current best and/or evidenced based practice. Facilities have a master copy of all policies and procedures and the related clinical forms. Facility staff are informed of changes/updates to policy at the various staff meeting however meetings have not been held regularly. A number of core clinical practices also have education packages for staff which are based on policies.  The quality programme includes an annual internal audit schedule that is not being implemented at Bupa Elizabeth R. Audit summaries and corrective action plans (CAPs) are not consistently completed where a noncompliance is identified.  Monthly clinical indicator data is collated across the facility monitoring rest home and hospital services. There is no evidence of trending of clinical data and development of CAPs when volumes exceed targets – e.g. falls and skin tears. There are falls prevention strategies are in place that includes, hi/lo beds, on-going falls assessment and exercises by the physiotherapist, and sensor mats. Interview with staff confirmed an understanding of the quality programme.  Bupa has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Bupa Elizabeth R was focusing to improve staff communication and have RNs complete the Bupa professional development programme. There is no progress towards these goals available as quality meetings have been held regularly (# link 1.2.1.1). Bupa Elizabeth R has confirmed annual goals for 2015 including reducing the number of resident’s falls and increasing the number of staff attending in-service education, however there is no progress towards these goals available (# link 1.2.1.1). Action Forms (QAF) are implemented in response to a facility quality initiative. There were examples at Bupa Elizabeth R including actions forms for laundry issues and care plan matrix documentation.  The Bupa group has completed a Care Home Health Check in March 2015 and has identified the shortfalls found during this audit. A corrective action plan has been developed to address the shortfalls. A quality manager is scheduled to spend time at the service from 4 May 2015 so as to fully implement the quality and risk programme and mentor the manager and clinical manager.  There is a health and safety, and risk management programme being implemented at Bupa Elizabeth R. The health and safety committee is part of the quality team however there have been no regular meetings. Incident data is collated by the clinical manger. There is a current hazard register. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Incident and accident data is collected and analysed and benchmarked through the Bupa benchmarking programme (# link 1.2.3.8). Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Relevant authorities were notified of an outbreak in March 2014. A sample of resident related incident reports for January 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. This was a previous audit finding that has now been addressed. Reports were completed and family notified as appropriate. Incidents and accident data is communicated to staff at staff handovers. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |
| 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 | The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed and included appropriate documentation. There has been a number of registered nurses resigned from their positions from October- December 2014, all for valid reasons. All these positions have been replaced and two other RNs are returning from parental leaving resulting in one extra RN being employed. Some staff have been employed at the service for a number of years and apart from the recent RN turnover the staff are stable.  The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff, however four staff were overdue for appraisals. There was an incomplete in-service calendar for 2014 and an incomplete schedule to date for 2015. Caregivers have an expectation to complete Bupa foundations skills as part of orientation, however this was not evidenced in two caregivers files reviewed. Four caregivers have completed an aged care education programme. The manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local DHB. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Bupa Elizabeth R has a two weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The roster is prepared six weeks in advanced and there are comprehensive processes to manage staff leave/replacement and day to day rostering. There is one registered nurse on duty at all times. There was sufficient staff observed to assist residents in the dining rooms with meals including the activities officer. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR. |
| 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 Moderate | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were five rest home residents self-administering on the day of audit and all had current competencies with three monthly review completed. All medications were securely and appropriately stored. Registered and enrolled nurses administer medications however not all competencies are current for staff that administer medications. The service uses robotic packs. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GP's however these have not been reviewed since July 2013. Staff sign for the administration of medications on medication sheets held with the medicines and this was documented and up to date in all 10 medication signing sheets reviewed. The medication folders include a list of specimen signatures.  Medication profiles reviewed were legible, up to date and reviewed at least three monthly by the G.P. All 10 medication charts reviewed have as needed medications prescribed with an individualised indication for use. Previous medication findings around documentation and transcribing have been addressed. The medication fridge has temperatures recorded daily and these are within acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The national menus have been audited and approved by an external dietitian. The service employs two cooks and kitchen assistants. Fridge temperatures are monitored and documented daily. All food containers are labelled and dated. Meals are prepared in the kitchen and served to residents from a bain maries in the rest home and delivered to the hospital in hot boxes.  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. Special utensils are available staff were observed assisting resident with food and fluids. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident centred care plans reviewed described the individual support and interventions required to meet the resident goals. This was a previous audit finding that has now been addressed. |
| 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 registered nurses initiate a review and if required, GP, gerontology nurse specialist or specialist consultation.  The caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. 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 three caregivers (rest home and hospital), two registered nurses, one unit coordinator (EN) from the rest home, four families interviewed, and the clinical manager. There is a short-term care plan that is used for acute or short-term changes in health status. Dressing supplies are available and a treatment room is stocked for use.  Wound assessment and wound management plans are in place for 10 wounds. One resident has two skin tears. Two residents with chronic ulcers have had input from the wound nurse specialist. There are two grade one pressure areas which are superficial. All wound assessments have completed short term care plans describing appropriate interventions and link to the long term care plan. This was a previous audit finding that has now been addressed. All wounds have been reviewed within the required 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 is one activity officer who is supported by the Bupa regional occupational therapist. There is a full and varied activities programme in place which is appropriate to the level of participation from residents with regular outings. On the day of audit residents in all areas were observed being actively involved with a variety of activities. The programme is developed monthly by the activities officer with input from residents, families 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 including community involvement.  Residents have an activities assessment completed over the first few weeks after admission and activities are included in the care plans. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed at least six monthly and are updated as changes were noted in care requirements. Care plan evaluations are comprehensive, relate to each aspect of the care plan and record the degree of achievement of goals and interventions. Short term care plans are utilised for residents and any changes to the long term care plan were dated and signed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service has a current warrant of fitness that expires 9 July 2015. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is the clinical manager and has completed training external training during 2014. This was a previous audit finding that has now been addressed. |
| 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 surveillance policy describes the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the IC coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly however this is not consistently reported at the quality meetings (# link 1.2.3.1).  The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the manager’s report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs (# link 1.2.3.8). 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. The service managed an outbreak appropriately in March 2014 and contacted relevant authorities immediately. The service had regular meetings through the outbreak, completed a tool box talk for staff and completed a full report of the outbreak. The service received a report of the outbreak from the district health board in April 2014. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregivers and nursing staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The service has one hospital and two rest home residents with bedrails on the enabler register. All have requested the use of the enabler. There are three residents using restraint in the form of t-belts or bedrails. Residents with restraint and using enablers require evaluation of restraint and enabler use for risk and safety (# link 2.2.4.2). |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner in one restraint file reviewed. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator. Evaluation timeframes are determined by risk levels. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. |

# 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 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Elizabeth had quality goals for 2014 including improving communication with staff and to have all RNs submit their professional development programmes by December 2014. The service has had one quality meeting in 2015 and has set goals for 2015 including having regular meetings, increase attendance at education sessions and implement an aged care programme. | There is no evidence of review of these goals for 2014 including progress towards meeting them. The service has had one quality meeting in 2015 and has set goals for 2015 including having regular meetings, increase attendance at education sessions and implement an aged care programme. There is no evidence of progress towards meeting these goals. | Ensure that all goals are reviewed and that progress towards meeting the gaols is documented and reported to staff at meetings.  90 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | Bupa has a quality and risk management system which is designed so that key components are linked to facility operations. | Bupa Elizabeth R has not fully implemented the quality and risk management system since previous audit. The audit schedule, meeting schedule, trending and analysing data is not fully implemented. | Ensure that the quality and risk system is fully implemented.  90 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 is a Bupa annual resident’s survey. Bupa Elizabeth R completed the survey in May 2014 with overall satisfaction of 79% | Results of the survey have not been communicated to the residents and a corrective action plan was not developed to address residents’ concerns. | Ensure that results of surveys are communicated to residents with details of how areas of concern are to be addressed.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | Bupa has an annual audit schedule to be implemented for measurement of achievement of quality and risk management of services. This was evident until July 2014. | Not all audits have been completed as per the Bupa schedule since July 2014. No audits were completed in February 2015, however the service completed extra audits in March 2015. | Ensure that all audits are completed as per the audit schedule to measure achievement against the quality and risk programme  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 Moderate | (i) The service conducts audits and has completed corrective action plans including but not limited to restraint (March 2015), environmental hygiene (March 2015) and continence product (March 2015). (ii) The service collates incidents and accident data and infection data and benchmarks with other Bupa facilities. “Red flag” areas require corrective action plans to address areas above the benchmark (KPIs). | (i) Not all audits where there has been areas requiring improvement have corrective action plans developed including (but not limited to) clinical file audit (March 2015), medication management (March 2015), food safety (March 2015), accident/incidents review (September 2014) and weight management (August 2014). (ii) Red flag areas of incidents including skin tears and falls above the bench mark indicators do not have corrective action plans developed and implemented to address these areas. | (i)& (ii) Ensure that all areas that require improvement from audits or benchmarking have corrective action plans developed and implemented.  60 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Staff appraisals are completed annually. Two staff were in the process of review and one staff member was not eligible for review. | Annual performance appraisals have not been completed for four of seven staff files reviewed. This shortfall has been identified by the Bupa facility healthcare check and a corrective action plan has been implemented to address this shortfall. | Ensure that all staff have an annual appraisal completed so as to allow opportunity for progress review.  90 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. | Two caregivers files reviewed do not have evidence that Bupa foundations skills have been completed and associated competencies completed. Foundation skills have only recently been introduced to the service. Two other caregivers are currently completing the orientation foundation skills. These shortfalls have been identified by the Bupa facility healthcare check and a corrective action plan has been implemented to address these shortfalls. | Ensure that all staff complete appropriate orientation and competencies so as to ensure safe care of residents.  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 | Bupa has a schedule for education to be completed across the group. In-service education is provided weekly/monthly. This ensures that staff are educated to provide safe and effective services to residents. Tool box talks are completed at the facility as required. | (i) The service has not fully completed the education schedule as per Bupa including but not limited to continence, falls prevention and nutrition/hydration in 2014 and abuse and neglect, code of rights, moving and handling and pain assessments 2015. (ii) Attendance at education has been low including but not limited to accidents and incidents (six), pressure injury prevention (five), care of the declining resident (7), continence (6) and wound care (6). (iii) Competencies have not been routinely completed annually for RNs, ENs and caregivers including moving and handling, restraint, assessments tools, syringe driver and wound care. These shortfalls have been identified by the Bupa facility healthcare check and a corrective action plan has been implemented to address these shortfalls. | (i),(ii) & (iii) Ensure that in-service is completed as per the Bupa schedule, that there is adequate staff attendance and that staff complete annual require competencies so as to ensure residents receive safe effective care.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | There is a list of medications approved by the GP as standing order kept in each medication folder. | The list of standing orders has not been reviewed since July 2013. | Ensure all standing orders are reviewed according to current best practice guidelines.  90 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Staff administering medications are required to complete medication competency annually. There are currently three RNs with medication competency and two new RNs that are orientating. There are eight RNs and two ENs who administer medications. One RN and one EN were observed safely and correctly administrating medications. There is and one caregiver on night shift that checks controlled medication with current competency | There are three RNs and two ENs who do have current medication competency including the clinical manager. A plan was immediately developed with the operations manager onsite to ensure there is a medication competency staff member always on duty and the remaining staff to be immediately trained. | Ensure that all staff administrating medications have medication competency completed annually and that there is always a medication competency staff member on duty.  30 days |
| Criterion 2.2.4.2  Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau. | PA Low | The service has documented evaluation of restraint every three months. One restraint file has been reviewed three monthly. | Two restraint files (hospital) and three enabler files (one hospital and two rest home) have not been reviewed three monthly. | Ensure that all restraint and enablers are reviewed three monthly or as determined by the restraint risk.  60 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.