# Bupa Care Services NZ Limited - Telford 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](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:** Telford 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: 18 August 2015 End date: 18 August 2015

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 50

# 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 Telford provides rest home and hospital level care for up to 53 residents and on the day of the audit there were 50 residents. The service is managed by an experienced care home manager. 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 the residents, family, management and staff.

Improvements continue to be required in relation to the four previous findings around the quality improvement programme, staff orientation and performance appraisals, aspects of care planning documentation, and aspects of medication management.

This surveillance audit identified the improvements are also required in relation to staff education and training, timeframes for completion of documentation, providing care interventions, resident and care plan reviews, communicating residents’ dietary requirements and enabler documentation.

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

Residents and families are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Complaints are being managed in a timely manner. Staff are aware of the complaints process and to whom they should direct complaints.

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

The business plan outlines goals and objectives for the year. The quality programme includes an internal audit programme, monitoring adverse events and a health and safety programme that includes hazard management. Residents are provided the opportunity to feedback on issues during resident meetings and via annual satisfaction surveys.

Human resources are managed in accordance with good employment practice, meeting legislative requirements. The orientation programme is specific to the employee’s job description. An education and training programme is in place for staff. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing. Caregivers, residents and family members report staffing levels are sufficient to meet residents’ needs.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in residents’ records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies and guidelines are in place. Registered nurses responsible for administration of medicines complete education and medication competencies.

A diversional therapist oversees the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme. Food service is provided on site and residents voiced satisfaction with the meals provided.

## 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. |

A current building warrant of fitness is posted in a visible location.

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

Restraint policy and procedures are in place. A register is maintained by the restraint coordinator. The service had three residents assessed as using an enabler and no restraint. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

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

The infection control surveillance programme is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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** | 0 | 8 | 0 | 3 | 6 | 0 | 0 |
| **Criteria** | 0 | 30 | 0 | 4 | 6 | 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 complaints policy describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaint process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with all six residents (four hospital level and two rest home level) and family members confirmed their understanding of the complaint process. Staff interviewed were able to describe the process around reporting complaints.  One complaint was lodged with HDC by family on 18 March 2015, was then retracted by the resident and was subsequently retracted by HDC. Afterwards the resident advised that she did support the family member’s complaint. HDC then recommended the Nationwide Health and Disability Advocacy Service become involved, which they did following prompting by the care home manager. A ‘complaint resolution agreement for ongoing actions’ was signed by the resident and care home manager on 30 April 2015. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policy guides staff on the process around open disclosure. A family communication sheet is held in the front of each resident’s file. Family are kept informed of any accident/incident unless the resident has consented otherwise, evidenced in all fifteen accident/incident forms reviewed. Interviews with the clinical manager confirmed family are notified following changes in health status. All five family interviewed (three with family in the rest home and two with family in the hospital) stated they were kept informed.  Monthly resident meetings provide a forum for residents to discuss issues or concerns on all aspects of the service. Access to interpreter services is available if needed.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. 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. The information pack is available in large print and can be read to residents who are visually impaired. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Telford Rest Home and Hospital is a Bupa residential care facility, situated in New Plymouth. They provide care for up to 53 residents. During the audit there were 26 (of 28) rest home level residents and 24 (of 25) hospital level residents living at the facility. In addition to the Aged Residential Care (ARC) contract, the facility holds the Long Term Chronic Support (LTCS) contract with the DHB. There were two hospital-level residents under the age of 65 under this contract.  A vision, mission statement and objectives are in place. Annual quality goals for the facility have been determined, which link to the overarching Bupa strategic plan. These goals are regularly reviewed with quarterly reports forwarded to the Bupa head office.  The facility is managed by an experienced care home manager who is a registered nurse (RN) and has worked in aged care in managerial and training roles since 2003. She has been employed at this facility since November 2014. She is supported by an experienced clinical manager/RN who has been in this role for one year.  The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is a quality and risk management programme in place. Interviews with the care home manager, clinical manager and staff (three caregivers, three registered nurses, one diversional therapist, one kitchen manager and one physiotherapist) reflected their general understanding of the quality and risk management systems.  Policies and procedures and associated implementation systems are in place with a document control system implemented through the head office. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in staff meeting minutes.  The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents’ falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Quality data is benchmarked against other similar Bupa facilities, however, the Bupa quality indicator corrective action template has not been routinely utilised where indicated. A selection of corrective actions documented January – May 2015 do not sufficiently reflect implementation. Quality and risk data, including trends in data, are posted in the staff room, however, they were not evident in staff meeting minutes. These previously identified improvements remain.  Falls prevention strategies are in place that includes the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. A falls committee is in place. A health and safety programme (Bfit) is currently in the process of being implemented. Health and safety goals are regularly reviewed. Hazard identification forms and a hazard register are in place. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for benchmarking against other similar Bupa facilities (link to finding 1.2.3.6). Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse.  The care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | A register of health professionals’ practising certificates is maintained. There are comprehensive human resources policies documented including recruitment, selection, orientation and staff training and development. Five staff files were randomly selected for review. The care home manager reports that she is in the process of completing performance appraisals but is behind schedule. This previously identified improvement remains.  The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are paired with experienced staff during their orientation and do not carry a clinical load. Four staff files selected for review were missing completed orientations. This previously identified improvement remains.  There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. There is an RN training day provided through Bupa that covers clinical aspects of care. Two RNs are signed off on InterRAI, two are in the process of completing their InterRAI and two RNs have yet to attend training.  A competency programme is in place with different requirements according to work type (eg, support work, registered nurse and cleaner). Core competencies are completed each year and a record of completion is maintained.  There is a minimum of one care staff with a current first aid certificate on every shift. Two kitchen staff have not completed a food safety qualification. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The care home manager and clinical manager are registered nurses who are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. There is separate cleaning and laundry staff. Activities staff provide activities for residents 42 hours per week. Interviews with the residents and relatives confirmed staffing overall was satisfactory. |
| 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 policies and procedures in place for safe medicine management that meet legislative requirements. The service uses the robotic packed medication system. Medication reconciliation is completed on delivery of medications and the signing sheet is signed by the RN checking the medications. There are weekly and six monthly controlled drug checks documented. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not being used. There were no residents self-medicating on the day of the audit.  There were issues identified with the prescribing of the route of administration for some medications. The previous audit finding relating to the requirement for documenting indications for use for ‘as required’ medications remains. All medication being administered had been prescribed. Not all medication being administered had been signed for. Not all medication charts reviewed, identified that the GP had seen and reviewed the residents medication three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | All meals at Bupa Telford are prepared and cooked on site. There is a six weekly seasonal menu, which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated however, this information is not always communicated to the kitchen staff. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier. Not all food services staff have completed training in food safety (link 1.2.7.5). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Previous certification audit identified that care plans did not record all interventions required to address the assessed needs of residents. In the sample of files reviewed it is noted that care plans evidenced incomplete care planning for all five residents. In interviews, staff reported they received adequate information for continuity of residents’ care. Regular GP care was implemented, sighted in current GP progress reports and confirmed at GP interview. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Three hospital and two rest home residents did not have interventions documented for all identified care needs (link 1.3.5.2). Monitoring forms were completed as required and evaluated by a registered nurse. An activities plan is completed on admission and reviewed six monthly with the care plan review (link 1.3.7.1).  Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure areas. One of seven wound care plans (hospital tracer), had no ongoing documented wound assessments or evaluations. One of seven wounds did not have the dressing changed as per the instructions on the wound care plan.  Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. RNs were able to describe access for wound and continence specialist input as required. |
| 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 | A diversional therapist and activities coordinator work a total of 42 hours per week providing the activities programme for the rest home and hospital residents. On the morning of audit, residents were observed being involved in activities. The programme is developed monthly and displayed in large print. A Map of Life and individualised activity plan is developed and reviewed as part of the care plan review (with exception link #1.3.3.3). Activities assessments and plans were not completed for all residents (link #1.3.5.2).  There is a range of activities offered that reflect the resident needs at Bupa Telford Rest Home and Hospital, and participation is voluntary. The programme is comprehensive and includes van outings, walking groups, gardening, pet visits, church services, and art and crafts. There are resources available for staff to use for one on one time with the residents and for group activities.  Activity participation sheets were maintained in files sampled. The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. Relatives and residents stated they were satisfied with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Four of five initial care plans sampled (one rest home, three hospital) were evaluated by the RN within three weeks of admission (link 1.3.3.3). Long-term care plans had been reviewed at least six monthly in three of five files sampled (one rest home, two hospital) or earlier for any health changes (link 1.3.3.3). Multi-disciplinary team meetings are held to review residents care. Evidence of three monthly GP reviews was not seen in all resident files sampled. On-going nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location - expiry date 20 July 2016. |
| 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 | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly, to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings (minutes sighted). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. Information and graphs are displayed for staff. The GP reviews antibiotic use at least three monthly with the medication review. There have been no outbreaks. Systems are in place appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had three residents using bedrails as enablers. No residents were using restraint.  Two residents’ files of residents using enablers were selected for review. Both files reflected links to enabler use in their care plan. The clinical manager reports that enabler assessments, voluntary consents and three-monthly reviews have been completed, but she was unable to locate these documents during the audit. She reported that she has temporarily misplaced the paperwork. |

# 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The care home manager provides regular reports to the Bupa head office. A monthly summary identifies cumulative data regarding the facility’s progress monitoring key indicators. Benchmarking reports are generated to review performance over a 12-month period. A corrective action form template is available but was not utilised where indicators were trending below the expected threshold. During instances where corrective action forms were completed (eg, internal audit findings), they were not consistently signed off to reflect evidence of implementation. Quality results are displayed in the staff room but were not being documented in the staff meeting minutes. | i) Corrective action plans are not being completed for benchmarked data that trends below acceptable thresholds. Seven of seventeen corrective actions did not reflect evidence of implementation; ii) Quality data, including corrective actions, are not being documented as having been discussed in staff meeting minutes. | i) Ensure corrective actions are developed and implemented where trends in data fall below accepted thresholds; ii) provide evidence that quality data, including corrective actions, are discussed in staff meetings.  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 previous certification audit identified that orientation documentation had not been completed for all staff. An orientation programme is in place, which is specific to worker type. Caregiver staff have three months to complete their orientation documentation. Four caregiver staff who were employed 1 January 2015 – 11 May 2015 had not submitted their completed orientation paperwork. The home care manager reports this is because they have not completed their orientation programme. Interviews with three caregivers advised that they believe that the orientation programme was sufficient. However, they stated that new caregivers are assigned to be paired with a range of other staff, which delays the new staff being signed off as competent. The orientation programme for the other staff (registered nurses, activities staff and kitchen staff) is adequate, confirmed in interviews with managers and staff, and orientation paperwork has been completed. | Caregiver staff are not completing their orientation programme in a timely manner. | Ensure new caregiver staff complete their orientation in a timely manner and are able to demonstrate competency before working independently with 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 | A comprehensive in-service education programme is in place that is complimented by staff completing a range of competencies throughout the year. Competency register and in-service attendance records are maintained. Two RNs are signed off on InterRAI, two are in the process of completing their InterRAI and two RNs have yet to attend training. The clinical manager reports that she has recently increased the frequency of in-services, which she reports will improve attendance rates. Not all kitchen staff have completed food safety qualifications.  Performance appraisals were not up-to-date for staff who had been employed for over one year in the sample of files reviewed. The care home manager is aware of this shortfall and reported that it was important that she knew staff well before completing their appraisals. | i) Two kitchen staff have not completed their food safety qualifications: ii) Annual performance appraisals were not completed in two of the five staff files reviewed. During further investigation, the care home manager reported that she is behind schedule because she wants to get to know the staff better before completing their appraisals. | i) Ensure that staff training is completed for registered nurses, ensure that there is a minimum of one staff on each night shift with a current first aid/CPR certificate, and ensure that the kitchen staff hold food safety qualifications; ii) provide evidence that annual performance appraisals are conducted for all employees.  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 Moderate | The GP prescribes all medication to be administered to the resident on admission. Medication reviews have not consistently been recorded three monthly.  Six of ten medication charts reviewed had medications prescribed correctly and eight of ten charts evidenced that medications prescribed had indications for use documented.  Two of ten medication charts had three monthly GP reviews documented. Six of ten medication charts reviewed had all medications administered and signed for correctly. | i) Four of ten medication charts reviewed (two rest home, two hospital) had medications prescribed with no route documented; ii)Two of ten medication charts reviewed (two hospital) had ‘as required’ medications prescribed with no indications for use documented; iii) Eight of ten medication charts reviewed (two rest home, six hospital) did not have three monthly GP reviews consistently documented; iv) Four of ten medication charts reviewed (two rest home, two hospital) had regular medications not signed for on the signing sheets. | i-iv) Ensure all medication documentation, prescribing, review and administration practices meet current legislative requirements and safe practice guidelines.  30 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Moderate | The registered nurse completes a nutritional profile on admission and updates this with the six monthly care plan review or earlier if the nutritional requirements change, however, two resident files reviewed noted a change in dietary requirements that were not communicated to the kitchen. | Two of five files reviewed (two hospital) had not had their special dietary requirements communicated to the kitchen. One resident changed to a high calorie diet and one resident changed to a high protein diet. | Ensure that all changes in dietary requirements are communicated to the kitchen in a timely manner.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | The RN is required to complete all aspects of the assessment, care planning and review of the care provided within the required time frames. In four of five residents’ files reviewed, the assessments and care plans had been developed within the required time frames. One rest home resident admitted in April did not have a care plan documented on the day of audit. Three of five residents’ files evidenced their care plans had been reviewed six monthly. | i) One rest home residents’ files reviewed did not have a care plan documented. The resident had been admitted to the facility 16 weeks prior: ii) Two of five residents’ files sampled (one rest home, one hospital) had not had their care plans reviewed six monthly. | i) Ensure that all residents have a care plan developed within the required time frames; ii) ensure that all care plans are reviewed six monthly or more frequently as required.  30 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Short-term care plans were developed when required and signed off by the RN when problems were resolved. Care plans reviewed for five residents did not evidence that all care requirements are documented for all assessed needs. InterRAI assessments have been completed for new residents and link to care plans. Activities plans for the sample of residents files reviewed were incomplete. Each resident is to have an activity plan developed in consultation with the resident and family within three weeks of admission and then the individualised activity care plan reviewed at least six monthly. | i) One rest home resident (link rest home tracer) with history of absconding and unexplained weight loss had no documented interventions in their care plan to manage the risk of absconding or weight loss; (ii) one hospital resident (link hospital tracer) with pain and chronic rash had no documented interventions in their long term care plans for pain management or a documented STCP; iii) one rest home resident on warfarin identified as a medium falls risk and at risk of bleeding had no interventions documented in the LTCP care plan to manage this risk; iv) one hospital resident who is palliative did not have an end of life care plan documented or LTCP updated to reflect current management; v) one hospital resident commenced on antibiotics for an acute infection did not have interventions documented in a short term care plan to manage the infection; vi) One of five residents’ files sampled (hospital) did not have and initial activity assessment or activity plan documented on file. | i-vi) Ensure that all residents’ care plans record the level of care and support required to meet the residents assessed needs.  30 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. Three hospital and two rest home residents did not have interventions documented for all identified care needs (link #1.3.5.2). Interventions for all assessed needs are not implemented for all residents reviewed.  The RN reviews information gathered through the use of monitoring charts to ensure interventions are documented in the care plans to reflect current care needs.  Wound assessments, treatment and evaluations were in place for six of seven current wounds (one ulcer, four skin tears, one chronic rash, and one wound). There were no pressure areas on day of audit. Adequate pressure management equipment and supplies were sighted. | i) one rest home resident had not been weighed monthly or the weighs consistently documented: ii) Two of seven wound care plans (two hospital) had no on-going assessment/evaluations of the wound documented: iii) One of seven wound care plans (hospital) did not have the dressing changed as frequently per the instructions on the wound care plan. | i) Ensure that residents receive all care interventions as per assessed needs; ii) ensure that that all wound care documentation and practice complies with the Bupa Telford wound care management policy; iii) ensure that all wound care is completed as per wound care plans and instructions.  30 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | The RN described evaluating information obtained through the use of assessment tools, progress notes and short term care plans to ensure interventions are documented in the care plans to reflect current care needs. Interventions for changes in care needs were not always documented in the care plan. Care plans are reviewed six monthly or with a change in care need. In the residents’ files reviewed, care plan evaluations were not all completed six monthly. Not all care plans reviewed included input from the MDT team. The GP completes a review of the resident at least every 3 months. The GP had not documented three monthly reviews in four of five files reviewed. | i) Four of five residents’ files sampled (one rest home, three hospital) did not have three monthly GP reviews documented; ii) Four of five residents’ files sampled (two rest home, two hospital) did not have the activity plan reviewed six monthly as part of the care plan review. | i) Ensure that the GP documents a review of all residents according to contractual requirements; (ii) Ensure that all activity plans are reviewed in accordance with Bupa policy.  60 days |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | Three residents are using bedrails as enablers. Links in two of two applicable residents’ care plans reflect the use of enablers. Completed assessments, consents and reviews for enabler use were unable to be located on the day of the audit but the clinical manager reports that she clearly remembers completing required documentation for all three residents using enablers. | Evidence of three enabler assessments, consents and reviews were misplaced and therefore unable to be evidenced during the audit. | Ensure documented enabler assessments, consents and reviews are found or duplicated.  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.

|  |
| --- |
| No data to display |

End of the report.