

Bupa Care Services NZ Limited - Whitby Rest Home & Hospital

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Bupa Care Services NZ Limited

Premises audited: Whitby Rest Home and Hospital

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

Dates of audit: Start date: 6 September 2016 End date: 7 September 2016

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: 92

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
	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

Whitby Rest Home and Hospital is part of the Bupa group. The service is certified to provide hospital (medical, geriatric), psychogeriatric, rest home and dementia level care for up to 104 residents. On the day of the audit, there were 92 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included review of policies and procedures; review of residents and staff files; observations; and interviews with residents, family, management, staff and a general practitioner.

The care home manager has many years' experience in aged care and management and has been in the role since February 2016. An experienced acting clinical manager supports the care home manager. An orientation and in-service training programme continues to be implemented that provides staff with appropriate knowledge and skills to deliver care. Residents and family advised that the staff provide a caring and homely environment.

This audit identified improvements required around; quality system, documented registered nurse follow-up, restraint documentation, medication documentation, and safety storage of chemical and oxygen.

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.
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Whitby Rest Home and Hospital endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Māori Health Plan supporting practice. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code of Rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with the community.

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 medium or high risk and/or unattained and of low risk.
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Whitby Rest Home and Hospital has identified quality goals and objectives for the year. There is an established Bupa quality and risk management system. An annual resident/relative satisfaction survey is completed and there are regular resident/relative

newsletters. Quality and risk performance is reported to the organisation's management team. There are four benchmarking groups across the organisation focusing on rest home, hospital, dementia, and psychogeriatric/mental health services. Whitby Rest Home and Hospital is benchmarked in all of these. There are human resources policies to guide practice and an 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. External training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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 low risk.
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There is a comprehensive admission package available prior to or on entry to the service. Resident records reviewed provide evidence that the registered nurses utilise the InterRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

There is an activities programme implemented for each unit, (ie, rest home, hospital, dementia and psychogeriatric units), along with shared activities as appropriate. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans.

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.

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

The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Hot water temperatures are monitored.

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.

A restraint policy includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as restraint and included in the policy. The service has seven residents on the register with restraint and four with enablers. Restraint includes bedrails and seating restraint. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in two monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The Bupa quality and risk team supports the infection control officer. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator 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 ongoing 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	0	44	0	5	1	0	0
Criteria	0	95	0	5	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Bupa policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents have been provided with information on admission, which includes the Code. Staff have received training about the Code and competency questionnaires are also completed. Interviews with eleven caregivers (from across all shifts and all units), three activities staff, one enrolled nurse and four registered nurses demonstrate an understanding of the Code. Four rest home and four hospital residents and ten relatives (six hospital, three dementia and one psychogeriatric) interviewed confirm staff respect privacy, and support residents in making choices were able.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There were signed general consents on all ten resident files sampled (two rest home, two psychogeriatric, two dementia and four hospital, including one LTCHC resident under palliative care, level of care residents). Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed. Discussions with caregivers, registered nurses (RN) and one enrolled nurse confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering

		<p>rooms.</p> <p>Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>Informed consent processes are also reviewed through the six monthly MDT review with residents and relatives and links to the quality system through annual satisfaction surveys.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code and information about advocacy services on entry. Interview with the care home manager and the acting clinical manager confirmed this occurs. Interview with residents confirmed that they are aware of their right to access advocacy. Interview with family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the files reviewed, there was information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The activities policy encourages links with the community. This was seen to be implemented with the activities programmes including opportunities to attend events outside of the facility. Residents and relatives interviewed informed visiting can occur at any time, and that the service encouraged involvement with community activities. Visitors were observed coming and going at all times of the day during the audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints procedure to guide practice. The care home manager has overall responsibility for managing the complaints process at Whitby.</p> <p>A complaint management record has been completed for each of the complaints received in 2016 and a record of all complaints per month had been recorded on the register. The register included relevant information regarding the complaint including date of resolution. Verbal complaints are included and actions and response are documented. Complaints are reported to head office monthly.</p> <p>Of the nine complaints reviewed, seven were care related and/or staff attitude, including one received through the Health and Disability Service commissioner. All complaints documented a thorough follow up. Discussion with the operation's manager, evidences that the service is aware of issues raised and processes are in place to support the service.</p> <p>The complaints procedure is provided to resident/relatives at entry and around the facility on</p>

		noticeboards. Discussion with residents and relatives confirmed they were provided with information on the complaint process. Complaint forms were visible for residents/relatives in various places around the facility.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. There is an opportunity to discuss these services prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed in the facility. The families and residents have been informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. The three monthly resident/relative meetings also provide the opportunity to raise issues/concerns, as well as resident specific, three monthly care reviews. Residents and relatives interviewed confirm information has been provided around the Code and the complaints process.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Ten resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and then integrated with the resident's care plan. There was evidence of family involvement. A tour of the facility confirmed there is the ability to support personal privacy for residents. There is an abuse and neglect policy, which is being implemented and includes staff in-service education.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Bupa has a Māori health plan that aligns with contractual requirements. There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Bupa Māori health policy was first developed in consultation with Kaumātua and is utilised throughout Bupa's facilities. Family/whānau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. This includes Ngati Toa and Porirua City Council as part of the youth to work programme, Postgate school, Aotea, Porirua and Mana collages gateway programme. Cultural needs are addressed in the care plan. One resident who identified as Māori had relevant cultural care documented in the care plan.

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau. Values and beliefs have been discussed at the initial care planning meeting and then incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The Code of Conduct is included in the employee pack. Job descriptions include responsibilities of the position and are in files reviewed. There are implemented policies to guide staff practice in respect of gifts. Clinical meetings occur and include discussion on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the acting clinical manager four registered nurses and an enrolled nurse confirmed an understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Services are provided at Whitby that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. All Bupa facilities, including Whitby, have a master copy of policies and procedures as well as related clinical forms. A number of core clinical practices also have education packages for staff, which are based on their policies. There are four benchmarking groups monitored across Bupa, of which Whitby is benchmarked against rest home, dementia, hospital and psychogeriatric indicators. Whitby is working to fully implement the Bupa quality and risk management system. All caregivers are required to complete foundations level two as part of orientation.</p> <p>Bupa has introduced leadership development of qualified staff including education from HR, attendance at external education, Bupa qualified nurses' education day and education sessions at monthly meetings. There are implemented competencies for caregivers, enrolled nurses and registered nurses. The standardised annual education programme, core competency assessments and orientation programmes were all seen to be being implemented at Whitby. There is a Bupa "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). Sixteen caregivers have attained bronze certificate; and two caregivers has attained silver certificate and one caregiver has reached a gold certificate.</p>

<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff on their responsibility around open disclosure. Incident forms reviewed identified that family had been notified following a resident incident. Relatives stated that they are informed when their family members health status changes. There is an interpreter policy and contact details of interpreters were available. 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 this can be read to residents. Information specific to the psychogeriatric and dementia unit is provided to family on admission.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Whitby is a Bupa facility that provides hospital, rest home, dementia and psychogeriatric level care for up to 103 residents. Occupancy on the day of audit was 92 residents. The dementia unit had 32 residents of a capacity of 33, this included one respite resident and one younger person (disabled). The psychogeriatric unit had 12 of 20 residents.</p> <p>The rest home was full with nine residents and the hospital had 38 of 41 residents (this included one palliative resident and one under the long-term chronic condition contract). The service has no dual-purpose beds.</p> <p>The philosophy of the service includes providing safe and therapeutic care for residents requiring specialised hospital level care (psychogeriatric), dementia care, rest home care and hospital care. Bupa have identified six key values that are displayed on the wall at Whitby. There is an overall Bupa business plan and risk management plan and a documented purpose, values, and direction. Each facility is required to develop annual quality goals. Examples of the 2016 goals at Whitby include reducing falls and continuing the Bupa B fit plans. Progress towards goals were reported through the various meetings, for example, the quality meetings, and staff meetings, a quarterly review of progress is also documented.</p> <p>The care home manager at Whitby is an experienced aged care manager (enrolled nurse) from another Bupa facility, who recently took over the management of the service (February 2016). He is supported by an experienced, acting clinical manager (registered nurse) who oversees clinical care. Recruitment for a permanent clinical manager is in process. Two newly employed unit coordinators are in place for the dementia unit and for the hospital and psychogeriatric unit. The wider Bupa management team that includes a supportive operations manager supports this new management team. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six monthly. The manager has maintained at least eight hours annually of professional development</p>

		activities related to managing a hospital.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence, the acting clinical manager provides cover for the manager's role, supported by the operations manager. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.
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	<p>There is a documented Bupa quality and risk management system, designed so that key components are linked to facility operations. The service has a series of meetings, including six monthly quality meetings, six monthly staff meetings, intermittent clinical meetings and three monthly resident, health and safety and infection control meetings. Quality data and quality outcomes are not documented as discussed at meetings.</p> <p>There is an internal audit schedule; however, internal audit outcomes are not documented as discussed at meetings. Post-audit action plans are documented where issues are raised; however, these are not always signed off as completed.</p> <p>The management has undertaken an internal audit of a selection of resident files each month. There are documented emails to RNs outlining gaps/shortfalls in documentation.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents. The service does not always document an action plan where incidents fall above the benchmark. There is no documented trend analysis and that supports ongoing quality improvements.</p> <p>Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p> <p>Policy review is coordinated by Bupa head office. The service has comprehensive policies/procedures to support service delivery including a policy around meeting InterRAI requirements.</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>	PA Moderate	<p>Incidents and accidents are documented. Incident forms reviewed had been completed comprehensively, reviewed by the clinical manager and signed off, however RN follow-up was not always documented in the resident files and neurological observation were not always documented for an acceptable period of time.</p> <p>Monthly gathering of incident data by type has been undertaken by the service and data was linked to the organisation's benchmarking programme and used for comparative purposes (link to 1.2.3.6). Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. Reportable events for 2015 and 2016 have included; (i) Police called to assist with one violent resident, and one resident who had absconded (both 2015). (ii) A resolved Health and Disability Commissioner complaint for 2016, and (iii) an outbreak of Norovirus May 2015, which was managed and resolved.</p>
<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>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 is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed and included all appropriate documentation.</p> <p>The service has a new management team who are being supported by the operations manager and an experienced care centre manager. There are also a number of new and relatively junior RNs in post. 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. There was a completed in-service calendar for 2016, which exceeded eight hours annually. Caregivers have completed either the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme.</p> <p>There are a total of 29 caregivers who work in the dementia and psychogeriatric units. Twenty of these have completed the required NZQA dementia standards. The other nine have been working there for less than twelve months and are enrolled. The acting clinical manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local DHB.</p> <p>There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. The caregivers undertake aged care education (Careerforce). Education and training for clinical staff is linked to external education provided by the district health board and through Bupa RN study days.</p>

		<p>Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has recently approved and validated their PDRP for five years. Bupa takes over the responsibility for auditing their qualified nurses. At Whitby, two qualified staff have completed PDRP.</p> <p>Nine of 11 registered nurses have completed InterRAI training.</p> <p>A competency programme is in place with different requirements according to work type (eg, support work, registered nurse, and cleaner). Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files).</p> <p>RN competencies include assessment tools, BSLS/Insulin administration, CD administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and T34 syringe driver.</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>An organisational staffing policy aligns with contractual requirements. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.</p> <p>The service has an acting clinical manager Monday to Friday.</p> <p>The psychogeriatric unit has a registered nurse on duty every shift. There are two caregivers each shift.</p> <p>In the dementia unit, there is unit coordinator (RN) who is employed from 08:00 – 16:00 Monday – Friday. She is assisted by five caregivers on the morning and afternoon shifts (one short shifts and three full shifts), and two caregivers work on the night shift.</p> <p>In the rest home, one caregiver is scheduled on the morning one in the afternoon and one at night and the hospital has seven caregivers in the morning and five in the afternoon, a mixture of long and short shifts. There is also a RN rostered 24/7 in the hospital unit. The unit coordinator and RNs from the hospital wing provides oversight to the rest home.</p> <p>A review of the roster and comparison with actual staffing evidences that there are sufficient staff on all shifts and that staffing matches the roster.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry, into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files</p>

identifiable, accurately recorded, current, confidential, and accessible when required.		were protected from unauthorised access by being held in locked cupboards. Care plans and notes were legible and where necessary signed and dated by a registered nurse. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration. An allied health section contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry, including specific information for dementia and psychogeriatric services. The admission agreement reviewed aligns with the service's contracts. Ten admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses, enrolled nurse and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. There are no standing orders. There was one self-medicating rest home resident on the day of audit. Self-medicating competency, three monthly reviews and monitoring was in place. The medication fridge has temperatures recorded daily and these are within acceptable ranges. Twenty medication charts were reviewed (three rest home, eight hospital, four dementia and three psychogeriatric). Photo identification was on all charts and charting met requirements. All medication charts had been reviewed by the GP at least three monthly. Eighteen of 20 resident

		medication administration-signing sheets corresponded with the medication chart. A shortfall was identified around the administration of regular medication on two resident's charts.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	<p>The food service team leader (qualified cook) oversees the food services and is supported by a chef, a cook in training and four kitchenhands. The Bupa national four weekly rotating summer/winter menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in three bain-maries and a hot box to each unit where they are served. The team leader receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated.</p> <p>End cooked food temperatures are recorded prior to placement in bain-marie or hot box. Fridges and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. A planned refurbishment of the kitchen was due to commence. On audit, all work surfaces were stainless steel and clean.</p> <p>Food service staff have completed on-site food safety education and chemical safety.</p>
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry were declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The facility has embedded the InterRAI assessment protocols within its current documentation. Bupa assessment booklets on admission and care plan templates were comprehensively completed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all files. Files reviewed across the rest home, hospital, dementia and psychogeriatric units identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, wound care and restraint were completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into

		care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. Overall, resident care plans sampled were resident centred and support needs and interventions were documented in detail (link 2.2.3.4 re: interventions around restraint). Residents and family members interviewed confirm they are involved in the development and review of care plans. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans reviewed included interventions that reflected the resident's current needs. When a residents condition changes the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers, RNs and the EN interviewed state there is adequate continence and wound care supplies. Wound assessment, wound management and evaluation forms were in place for all wounds in the rest home and hospital (four ulcers including one carcinoma). In the psychogeriatric unit, there was one ulcer and on day of audit, there were no wounds in the dementia unit. Supra pubic catheter sites were included in the wound log. There were four pressure injuries, three of which were facility acquired. Specialist wound advice is available as needed and this could be described by the RNs interviewed. Monitoring charts were utilised and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	The service employs four activity coordinators who between them work 127.5 hours per week, covering Sunday to Friday. They have over twenty years' experience between them. All coordinators have attained recognised units of learning in dementia, hold a current first aid

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>certificate and attend the six monthly Bupa workshops and on-site in-service. There is a programme running in each of the four units (psychogeriatric, hospital, rest home and dementia) to meet the identified needs of the residents. This programme is printed for all (available throughout the facility and in individual bedrooms) and many activities are integrated with residents moving from unit to unit for some activities.</p> <p>Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. Activities meet the abilities of all resident groups. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. A volunteer is involved in the activity programme running a craft group. Entertainers come twice weekly (including the weekend). There is a range of activities including a staff member who is a pianist, visiting pets, kindergarten groups, school and cultural groups that reflect the culture of many of the residents. Residents go on regular outings and drives in the Bupa Whitby wheelchair hoist van.</p> <p>Residents are encouraged to maintain links with the community and some attend church services in the community.</p> <p>The family/resident completes a Map of Life on admission, which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated into the 'My Day My Way' care plan, and is reviewed at the same time as the care plan in all resident files reviewed.</p> <p>Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys.</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 reviewed had been evaluated by registered nurses' six monthly, or when changes to care occurred in nine of ten resident files reviewed (one sampled file was of a resident in the dementia unit who had not been at the service six months). Written evaluations describe the resident's progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six monthly reviews. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three monthly review by the medical practitioner. There was evidence that family members are invited to have input into the multidisciplinary care plan reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is</p>

(Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the unit coordinators and RNs identified that the service has access to a wide range of support either through the GP, the care coordinator at the DHB, Bupa specialists and contracted allied services.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Low	There is a chemical/substance safety policy and waste management policy. Management of waste and hazardous substances is covered during orientation of new staff. Chemicals are stored safely in locked cupboards. Safety datasheets and product wall charts are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff at the point of use. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Staff have attended chemical safety training with the approved provider for chemicals. There was a shortfall in the labelling of chemicals and storage of oxygen cylinders.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building has a current building warrant of fitness dated 24 June 2016. Reactive maintenance (maintenance requests logbooks) and a 52 week planned maintenance schedule are in place and maintained. A maintenance person is employed and on interview indicated a good understanding of providing a safe and appropriate environment for residents. Medical equipment including hoists and weighing scales have been calibrated. Electrical testing and tagging has been completed annually. The hot water temperatures are monitored fortnightly at delivery point and are maintained between 43-45 degrees Celsius. The maintenance person is on call and there are contractors for essential service available 24/7.</p> <p>The environment is light and roomy providing a range of sitting areas for the residents in each of the units with good visibility of residents as appropriate. Mirrors and CTV cameras are present in the psychogeriatric unit.</p> <p>The wide corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating and shaded areas. There is safe wheelchair access to all communal areas.</p> <p>There is a secure garden off the dementia unit and one off the psychogeriatric unit.</p> <p>The caregivers and RNs interviewed stated that they have all the equipment referred to in care</p>

		plans necessary to provide care.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All resident rooms have access to hand basins. Not all rooms have ensuites. There are adequate numbers of communal toilets and shower rooms. There are communal toilets located close to communal areas in the psychogeriatric, dementia and hospital areas. Toilets have privacy locks. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Residents interviewed report their privacy is maintained at all times.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The rest home, hospital, dementia and psychogeriatric rooms are spacious enough to manoeuvre transferring and mobility equipment, to deliver the assessed level of care. Residents are encouraged to personalise their bedrooms as desired.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each unit has a lounge and dining room. The hospital and rest home also have a large lounge, which is used by all residents as appropriate. The dementia and psychogeriatric units have additional separate quiet lounges. Residents (as able) were observed to be moving freely with the use of mobility aids. Furniture was well arranged to facilitate this. Seating (including specialised hospital chairs) and space is arranged to allow both individual and group activities to occur.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry and personal clothing is laundered on-site. There are two laundry persons on duty Monday to Friday and one on Saturday and Sunday. There are defined clean/dirty areas. Cleaner's trolleys are stored in locked areas when not in use. There were adequate linen supplies sighted in the facility linen-store cupboards. Internal audits monitor the effectiveness of laundry and cleaning processes. The chemical provider audits the effectiveness of chemicals for laundry and cleaning services (link 1.4.2.1). Residents and relatives interviewed are happy with the laundry and cleaning services provided.

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills are undertaken six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting. There are civil defence kits in the facility and stored water. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility has radiator heating throughout the personal and communal areas. All communal areas and bedrooms are well ventilated and light. Residents and family interviewed, stated the temperature of the facility is comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and the description of the infection control programme are available. There is a job description for the infection control (IC) coordinator and clearly defined guidelines. The infection control programme is linked into the quality management programme. The infection control committee meets three monthly. The IC programme is reviewed annually at head office. The facility has developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. Bupa have a regional infection control group (RIC) for the three regions in NZ.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the	FA	The infection control committee is made up of a cross section of staff from all areas of the service. The facility also has access to an infection control nurse specialist, public health, GPs and expertise within the organisation.

organisation.		
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. There is also a 'scope' of the infection control programme, standards for infection control, infection control preparation, responsibilities and job descriptions, waste disposal, and notification of diseases. Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control officer is responsible for coordinating/providing education and training to staff. The IC coordinator (RN) is suitably skilled and trained to manage infection matters. The orientation package for new staff includes specific training around hand washing and standard precautions. There has been infection control training provided as part of the annual education schedule. Toolbox sessions are also used opportunistically to maintain staff knowledge. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.
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. The IC coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infection control data is collated monthly and reported at the three monthly infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	A regional restraint group at an organisation level reviews restraint practices. A Whitby two monthly restraint committee is responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are

restraint is actively minimised.		<p>clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures. Discussion with the restraint coordinator (RN) confirms the service commitment to reducing restraint use.</p> <p>There were four residents with enablers in the hospital, all bed rails. There was one resident with bedrails as restraint in the psychogeriatric unit. The hospital has seven residents with restraint; five bedrails and four T belts (some residents had both). All restraint use is recorded on a restraint register.</p> <p>Files for three residents with restraint were reviewed, one from the psychogeriatric unit and two from the hospital and one enabler from the hospital, (link to 2.2.3.4).</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator is a registered nurse. The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions included the restraint coordinator, clinical manager, registered nurses, resident/or family representative and medical practitioner. Restraint use and review is part of the two monthly restraint meeting.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, clinical manager, registered nurses, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. Assessments and approvals for restraint were fully completed. These were sighted in the three restraint files reviewed and one enabler file reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are followed. An assessment form/process was completed for all restraints. The four files (three restraint and one enabler) reviewed all had a completed assessment form, but not all care plans included reference to the restraint or enabler and the risks associated with their use. Monitoring forms that included regular two hourly monitoring (or more frequent) were not always present in the restraint files reviewed or for the</p>

		enabler. Consent forms detailing the reason and type of restraint were completed. The service has a restraint and enablers register, which had been updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the four files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices were reviewed on a formal basis every month by the facility restraint coordinator at quality and also two monthly restraint meetings. Evaluation timeframes were determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews were completed three monthly or sooner if a need is identified. The restraint coordinator completed reviews. Any adverse outcomes were included in the restraint coordinators monthly reports and were reported at the monthly meetings. Restraint use is reviewed as part of the quality team meeting.

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	Bupa has a robust and comprehensive quality system and process. The new management team at Whitby is in the process of ensuring the full implementation of the process. Meetings are documented six monthly for quality and staff, and not always monthly for registered nurses. Quality information is not documented as	(i) There were two staff meetings and two quality meetings documented for 2016. Clinical focused meetings have not always occurred monthly. (ii) Quality information is not documented as discussed, at the meetings (eg, such as audits outcomes, complaints, infection control and incidents and accidents). (iii) There is no documentation to evidence that trends are reported, analysed and action plans implemented as needed. (iv) There was no documented evidence that action plans have been utilised as a result of analysis of benchmarking outcomes, (eg, high falls in the rest home for June and July and high urinary tract infections in the hospital	(i) Ensure that meetings take place according to the meeting schedule. (ii) Ensure that quality data and outcomes are reported and discussed at meetings. (iii) - (iv) Ensure that trends analysis is undertaken,

		<p>discussed at meetings. Incident and accidents are collated monthly and benchmarked across all of the service areas. Each month, information is provided to the service illustrating areas where incident falls outside the Bupa acceptable ranges. There is no documented evidence that the service has utilised the clinical indicator – corrective action forms to address areas above the benchmark.</p>	<p>January, February March and June).</p>	<p>reported and followed-up. 60 days</p>
<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>	<p>PA Moderate</p>	<p>Incident and accident forms are completed for all incidents, accident and unwanted events. Incident forms reviewed had all been reviewed and signed off by an RN. Not all documentation reviewed, identified ongoing assessment and evaluation by an RN post-incident, and neurological observations were not</p>	<p>Registered nurse follow-up following resident related incidents was not always documented to ensure resident safety and ongoing care and monitoring. This included neurological observations not being undertaken for an appropriate length of time following a blow to the head or unwitnessed fall for two dementia residents, three hospital residents, and two psychogeriatric residents. For these residents neurological observations were undertaken for an average of twice only. Incident forms were followed up to the resident files for; two dementia residents, one hospital resident and one</p>	<p>Ensure that post incident monitoring such as neurological observation are documented according to Bupa timeframes. Ensure that RNs document a follow-up review of residents post</p>

		documented as undertaken for an appropriate length of time.	psychogeriatric resident. The hospital resident had sustained two falls for August. While, the care plan did reflect this risk, one of the falls had no documentation in progress notes (or elsewhere) to reflect the resident had been reviewed post-fall. One dementia resident had possibly been poked in the eye. There was no documented RN review of this resident other than immediate post injury review.	injury. 60 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	Eighteen of twenty medication charts reviewed met legislative requirement. Discontinued medications were dated and signed by the GP. All 'as required' medications had an indication for use. An electronic system for signing for medication administration was used. On two of the medication charts reviewed, signing had not occurred, as the medications had not been administered.	One resident who was charted regular pain relief did not have it documented as administered. On interview, the RN stated the family had requested it not to be given. The GP had not been contacted or altered the medication order. Regular medication was not documented as administered to a resident twice in one day with no reason recorded as to why it was not given.	Ensure medication administration is documented in line with legislation, protocols, and guidelines. 90 days
Criterion 1.3.13.5	PA Low	Storage of food in the	There was no evidence that temperatures	Ensure all

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		kitchen was in line with relevant standards and guidelines including the recording of the temperatures of fridges and freezers containing food. There was a shortfall in the servery areas where fridge temperatures were not recorded so evidence was lacking that food was safely stored.	of three servery fridges containing resident food were monitored or recorded.	food is stored at the correct temperature and documentation reflects this. 90 days
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Low	Chemicals were stored in clearly marked containers provided by the chemical supplier with the exception of two containers of chemicals. Oxygen cylinders had a dedicated storage area within the facility to secure cylinders. There was a shortfall in securing all cylinders.	(i) In the dementia unit there were two unlabelled containers of chemicals on the cleaner's trolley. (ii) Three oxygen cylinders were not secured in the storage area.	Ensure chemicals are stored safely. 30 days
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its	PA Low	The consent and assessment process of enablers and consent were documented, including the	One restraint file in the psychogeriatric unit did not have the bedrail restraint included in the care plan. One restraint in the hospital had the restraint included in the care plan, but not the risks associated with	Ensure that care plans document the restraint or enabler in use

<p>outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. 		<p>consideration of alternatives. Family were documented as being part of the process, the documentation of restraint and enabler use and risks associated with its use was not always in place. Monitoring of restraint and enablers was not always undertaken.</p>	<p>its use. The enabler file reviewed in the hospital included the enabler on the care plan, but not the risks associated with its use. One hospital resident was not monitored according to timeframes and one hospital enabler was not monitored through progress notes as directed by Bupa policies.</p>	<p>and the risks associated with their use. Ensure monitoring is documented as directed.</p> <p>30 days</p>
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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, there 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.