Bupa Care Services NZ Limited - David Lange Care Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	David Lange Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 24 August 2016 End date: 24 August 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: 86

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

Bupa David Lange provides rest home and hospital level care for up to 87 residents and on the day of the audit, there were 86 residents. The service is managed by a care home manager and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service has addressed six of seven shortfalls from the previous certification audit around corrective action planning, notification of outbreaks, attendance at staff training, response to call bells, environmental restraint, and care planning.

Improvements continue to be required in relation to care interventions.

This surveillance audit did not identify any other areas for improvement.

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 family members interviewed confirmed that the service communicates in an effective manner. Complaints and concerns have been managed and a complaints register is maintained.

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.		Standards applicable to this service fully attained.

Bupa's David Lange Care Home is implementing the organisational quality and risk management system that supports the provision of clinical care is implementing the organisational quality and risk management system that supports the provision of clinical care. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided 24 hours a day, seven days a week.

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.

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information in the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months. The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings, and celebrations. Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on site.

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.		Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The service adheres to restraint management processes. On the day of audit, the service had three residents using restraint and seven residents using enablers.

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 service. 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	16	0	0	1	0	0
Criteria	0	39	0	0	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility and are available in seven languages. Twelve complaints received since February 2016 were reviewed with evidence of appropriate follow-up actions taken. One complaint has been made to Health and Disability since the previous audit, no further action was required and this complaint has now been closed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Twelve accident/incident forms reviewed (from July 2016), identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.

provide an environment conducive to effective communication.		An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated and the service is introducing the use of I-pad (Skype application) technology to support contact with families for assistance with translation.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	David Lange Care Home and Hospital is a Bupa residential care facility. The service currently provides hospital (medical and geriatric), rest home and residential physical disability care for up to 87 residents. On the day of the audit, there were 86 residents. There were five residents at hospital level admitted under the residential disability (physical) services contract with another funder, and two hospital residents admitted under a transitional care contract with the DHB. All other residents were under the aged related residential care contract. There were no respite residents. The service is delivered across three floors and all beds are dual-purpose. On the ground floor, there are 23 beds and on the day of audit, there were 20 rest home residents, one hospital resident, one transitional care resident and one empty bed. On level two, there are two wings. Pegasus can cater for up to 20 residents and on the day of audit, there were 10 hospital level residents, three residents under the residential disability (physical) services contract (hospital), one transitional care resident and six rest home residents. Phoenix ward caters for 22 residents and on the day of audit, there were 20 hospital level care, one resident at rest home level of care and one resident under the residential disability (physical) services contract (hospital). On level three there are 22 beds and on the day of audit there were two rest home residents, one resident under the residential disability (physical) services contract (hospital) and 19 hospital level residents. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. David Lange Care Home and Hospital is part of the Northern One Bupa region and the managers from this region meet quarterly to review and discuss the organisational goals and their progress towards these. The care home manager provides a weekly report to the Bupa operations manager. The operations manager teleconferences weekly and monthly one on one meetings are held and completes a report to the director of care homes and rehabilitation. A quarterly report is prepared by the care home manager and sent to the Bupa quality and risk team on the progress and actions that have been taken to achieve the Bupa David Lange quality goals. Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. The care home manager has been in the role since June 2015. The care home manager is a registered nurse with a current practising certificate. A clinical manager has been in the role since December 2014. Staff spoke positively about the support/direction and management of the current management team.

		The care home manager and clinical manager have 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.	FA	A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies, procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident 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 and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. The previous audit finding related to corrective action plans has been met. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Quality initiative projects are in place around behaviour management, and reduction in skin infections, which are beginning to have a positive impact on resident outcomes. The service has a strong focus on implementing a “culture of kindness” in everything they do. The service has implemented the Cultural and Linguistically Diverse (CALD) programme as part of the overall goal to be recognised as a centre of excellence in relation to being a culturally responsive and inclusive service. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The organisation holds tertiary accreditation by ACC for their workplace safety management programme.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the	FA	Individual reports are completed for each incident/accident, with the immediate action noted and any follow-up action(s) required. Each event involving a resident reflected an initial clinical assessment by a registered nurse. Follow-up actions had been fully completed. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Twelve accident/incident forms were reviewed. Incidents are benchmarked and analysed for trends. Discussions with the care home manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notifications were made around two outbreaks since the previous audit and for one stage-four pressure injury. No other essential

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		notifications have been required. The previous audit finding related to essential adverse event reporting has been met.
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.	FA	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one clinical manager, two registered nurses, one caregiver, one activity coordinator, one maintenance person, one cook, and one cleaner) evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type, and includes documented competencies. New staff are buddied for a period. Caregivers complete an orientation booklet that has been aligned with foundation skills unit standards. There is an annual education and training schedule being implemented. All staff are required to attend one of the four full training days per year that is relevant to their role (clinical or non-clinical) which covers the mandatory educations. Additional training is provided as one of sessions throughout the year and opportunistic education is provided via toolbox talks. Staff are supported and encouraged to attend education and training provided externally. The previous audit finding related to attendance at education has been met. A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained. Specific registered nurse competencies are completed. Nine of thirteen registered nurses are InterRAI trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	FA	The staffing levels meet contractual requirements. Staffing is designed to cater appropriately for the mix of residents on each level and residents report call bells are answered in a timely manner. Call bell response times are monitored and the results communicated to staff. The previous audit finding related to call bell response times has been met. The care home manager and the clinical manager are on-call after hours. The care home manager and clinical manager are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory.

and/or experienced service providers.		
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.	FA	Twelve medication charts were reviewed – eight hospital and four rest home. There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one hospital resident self-administering on the day of audit. A consent form had been signed and the medication was stored appropriately. There is one medication room and three medication trolleys. All medications were securely and appropriately stored. The facility uses a robotic pack system. Senior caregivers who have passed their competency, administer medications to rest home residents. Medications for hospital level residents are administered by RNs. Medication competencies are updated annually. Syringe driver training is provided by the local hospice. Medication charts have photo IDs. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Standing order medications have been approved by the GP. These meet the guidelines. Staff sign for the administration of medications on medication sheets held with the medicines and this was documented and up-to-date in all twelve medication signing sheets reviewed. The medication folders include a list of specimen signatures. Medication profiles reviewed were legible, up to date and reviewed at least three monthly by the GP. All medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service employs one head cook (Monday-Friday) and one weekend cook. There are two kitchenhands employed each day. All kitchen staff have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked onsite. Meals are delivered to the units in bain-maries. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. These were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets were noted on the kitchen notice board, which can be viewed only by kitchen staff. The national Bupa menus have been audited and approved by an external dietitian. There is also a daily Asian/Indian menu and a Pacific Island peoples menu three times a week. The head cook has implemented a monthly Maori menu. Residents and families interviewed were very happy with the meals provided.
Standard 1.3.5:	FA	Care plans reviewed were comprehensive and evidenced multidisciplinary input in the care of the resident. All care plans were resident-centred and documented support needs to achieve the resident goals. Care plans were

Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		documented to meet the assessed care needs of the resident in the resident files reviewed. The previous audit finding related to care planning has been met. Residents and families state that they are involved in the care planning process. 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 if an ongoing problem.
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	All care plans reviewed included documentation that meets the needs of the residents, and all care plans had been updated as residents' needs changed. An interview with the GP evidenced that care provided is of a high standard and he is kept informed. Family members agreed that they are involved in the care planning. Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. There are currently sixteen wounds, 14 hospital residents with wounds (4 skin tears, two ulcers, two scabs, one boil, one breast malignancy and four pressure injuries) and two rest home residents with wounds (one skin tear and one chronic ulcer). All resident wounds have appropriate care documented and provided, but not all wounds have been reviewed according in the stated timeframe. Access to specialist advice and support is available as needed. Monitoring forms are in use such as weight, blood pressure and turning charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is one activities coordinator (40 hrs weekly) and three activities assistants, (two employed 20 and one 35 hours weekly). All four have attended BUPA activities study days. The activities coordinator has had training by the physiotherapist, and supervises residents' daily exercises and walks, when the physiotherapist is not present. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The Bupa activities programme template is designed for high end and low end cognitive functions and caters for individual needs. The programme is developed monthly and displayed in large print and colourful illustrations. Residents have an assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family, and culture. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. Church groups visit weekly. There are van outings. Events such as birthdays, Easter, Mother's Day are celebrated. All residents are encouraged to attend community events/groups but particular encouragement is given to YPD residents.
Standard 1.3.8: Evaluation Consumers' service	FA	Long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurred. Short-term care plans for short-term needs were evaluated and signed off as resolved, or added to the long-term care plan as an ongoing problem. Activities plans are evaluated at the same time as the long-term care

delivery plans are evaluated in a comprehensive and timely manner.		plans. Family members confirmed that they are informed of any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires on 18 April 2017.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the IC coordinator. Infection control data is reported at the quality, infection control and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There have been two outbreaks since the previous audit and all appropriate notifications were made.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There are restraint and enabler registers. There are currently three hospital residents using restraint and seven hospital residents with enablers. Documentation was reviewed for one restraint and five enablers and evidences assessment, authorisation, consent, planning, monitoring and review of the devices. There are no environmental restraints in use. The previous audit finding related to the use of environmental restraint has been met.

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 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	There is a weight management programme in place. Weights are monitored monthly or as required and if there is a percentage weight loss or gain, residents are referred to the dietitian who recommends a suitable diet regime. Turning charts are in use and are consistently documented every one – two hours. These aspects of the previous finding have been addressed. Wound care management plans are in place, however not all wounds were reviewed according to the instructions in the wound care plan.	Two of three rest home resident wounds have not been reviewed within the stated timeframe.	Ensure all wounds are reviewed within the stated timeframe. 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.