# Bupa Care Services NZ Limited - NorthHaven Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** NorthHaven Hospital

**Services audited:** Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Rest home care (excluding dementia care); Residential disability services - Physical

**Dates of audit:** Start date: 5 December 2016 End date: 6 December 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:** 94

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Bupa NorthHaven Hospital is certified to provide residential disability level care (intellectual and physical); psychogeriatric level care; hospital (geriatric and medical) and rest home care for up to 106 residents. During the audit, there were 94 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

The care home manager is appropriately qualified and experienced. Interviews with residents and relatives confirmed overall satisfaction with the care and service provided.   
The one shortfall identified at their previous audit has not been addressed. This was around ensuring care plans reflected resident need.

Further improvements are required around completing reviews and assessments within the required timeframes, medication fridge temperature monitoring, improving attendance at staff education sessions and ensuring kitchen cleaning schedules are adhered to.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Residents and family are well informed including of changes in resident’s health. The care home manager and clinical manager have an open-door policy. Complaints processes are implemented and complaints and concerns are managed and documented and learning’s from complaints shared with all staff.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Bupa NorthHaven Hospital has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. The facility is benchmarked against other Bupa facilities. Incidents documented demonstrated immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The activities team provide an activities programme for the residents in each area that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

All meals are prepared on-site. Food, fridge and freezer temperatures are recorded. Residents, family/whānau interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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

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

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a Bupa restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were nine restraints and two enablers being used.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The 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.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 11 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 32 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the care home manager using a complaints’ register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner (HDC).  Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestion box are placed at reception.  Seventeen complaints were received in 2016. All complaints reviewed reflected evidence of responding to complaints in a timely manner with appropriate follow-up actions taken. All complaints were signed off by the care home manager as resolved. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | 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. Twenty accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member’s health status changes.  An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.  An introduction to the psychogeriatric unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident’s handbook providing practical information for residents and their families.  Prospective residents or their representative/EPOA are advised that there are a number of shared rooms in each unit. Advised by care home manager that verbal consent is gained prior to admission (when visiting to view the room available) should a bed in a shared room be the only one available. All shared rooms are occupied by same sex residents and privacy curtains were sighted in shared rooms to maintain resident’s privacy and dignity. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa NorthHaven provides hospital, rest home, psychogeriatric and residential disability - intellectual/physical for up to 106 residents. There were two rest home level residents and 52 hospital level residents in the hospital/rest home units. There were 38 residents in the two psychogeriatric units. Additionally, there was one resident under the residential disability contract -physical (in the hospital), one respite care (hospital) and one hospital resident on a medical- interim care contract.  Bupa NorthHaven is a two storey building with hospital/rest home services being provided on the first floor. This unit has five dual purpose beds. Two of which were occupied by rest home residents. There is another hospital unit located on the ground floor. Two psychogeriatric units (one with 20 beds and one with 22 beds) are also located on the ground floor.  A vision, mission statement and objectives are in place. Annual goals for the facility have been determined and are regularly reviewed by the care home manager and staff.  The service is managed by a care home manager who trained as a registered nurse with a current practising certificate. The care home manager has worked for Bupa for twenty years and has been in this role at NorthHaven since 2013. The clinical manager commenced the role in April 2015. The care home manager and CM are supported by a Bupa Regional Manager and two unit coordinators/RNs.  The care home manager and CM 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 | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the Bupa regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. 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): residents’ falls, infection rates, complaints received, restraint use, pressure areas, wounds and medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the quality and applicable staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. A corrective action plan was currently being implemented following a recent increase in skin tears and pressure injuries noted to be above the national benchmarking range in November 2016. Caregivers and RNs interviewed were aware of the corrective actions and described receiving toolbox education sessions on falls preventions, moving and handling and skin care.  A corrective action plan is also in place following feedback received from Customer feedback survey 2016 were the overall satisfaction rate was 76%.  Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety committee. Nine health and safety representatives were interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. An employee health and safety programme (Bfit) is in place, which is linked to the overarching Bupa National Health and Safety Plan.  Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms. Toileting plans and intentional rounding are examples of strategies being implemented. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system.  The care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided which included Section 31 notifications to the Ministry of Health when a resident absconded and notification of pressure injuries. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (two RNs, three caregivers, one activities coordinator, one unit coordinator, one kitchen manager and one clinical manager) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.  The care home manager reported that a number of experienced registered nurses had left the facility this year due to relocation or for career advancement. The registered nurses employed have been provided with extra education sessions provided by the Bupa education officer to ensure a robust orientation and clinical competence.  The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. The overall attendance for education sessions was evidenced to be low.  Twenty-four caregivers are employed to work in psychogeriatric units with eighteen having completed their national dementia qualification. Six caregivers are in the process of completing their qualification and have been employed for less than one year. Three activity staff have completed dementia qualification.  Registered nurses are supported to maintain their professional competency. Sixteen registered nurses are employed and eight have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a care home manager Mon - Fri and a clinical manager (registered nurse) Mon - Fri. There are two hospital and one psychogeriatric unit coordinator’s (all registered nurses), who work Mon-Fri. The unit coordinator for the psychogeriatric units oversees both psychogeriatric units.  RN cover is provided twenty-four hours a day, seven days a week with a minimum of two RNs scheduled at any one time. One RN is always on duty covering the two psychogeriatric units and one across the hospitals. Registered nurses are supported by sufficient numbers of caregivers. Separate laundry and cleaning staff are employed seven days a week.  Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| 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 | Fourteen medication charts were reviewed (two rest home, eight hospital - including one interim care, one respite and one under 65, and four psychogeriatric). There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication management system. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed could describe their role regarding medicine administration.  Standing orders are not in use. Two rest home residents self-medicating have been assessed and reviewed as per policy. All medication charts reviewed met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. Anti-psychotic management plans are used for residents in the psychogeriatric units when medications are commenced, discontinued or changed. The psychogeriatrician and or GP reviews the anti-psychotic management plans at least monthly or earlier if required. The medication fridge temperatures are required to be checked and recoded daily however medication fridge temperatures had not been consistently recorded. |
| 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 | All meals at Bupa NorthHaven are prepared and cooked on-site. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Meals are delivered in scan boxes to each unit dining area. Resident’s individual likes and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Additional nutritious snacks are available in all areas over the 24-hour period.  Staff were observed assisting residents with their meals and drinks in the psychogeriatric unit. Supplements are provided to residents with identified weight loss. Shortfalls were noted around the communication to kitchen staff of residents with weight loss. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfaction with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded for each meal. Shortfalls were noted in relation to the safe storage of food and the completion of scheduled cleaning records. The dishwasher is checked regularly by the chemical supplier.  All food services staff have completed training in food safety and hygiene and chemical safety. |
| 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 | A written record of each resident’s progress is documented. Resident changes in condition are followed up by a registered nurse as evidenced in residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. De-escalation techniques are documented for residents with behaviours. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications.  Where short-term care plans were documented, they were reviewed and if required linked to the long-term care plan. However, interventions were not documented for all residents with weight loss. The previous audit finding related to interventions to meet resident’s current needs remains.  Dressing supplies are available and treatment rooms were well stocked for use. Wound initial assessment plans and wound evaluations were completed for 15 of 15 wound care plans reviewed. There has been wound nurse specialist and GP involvement in the care of pressure injuries.  Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Registered nurses could describe access to continence specialist input as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities staff provide an activities programme over seven days per week. There is a qualified diversional therapist based in the psychogeriatric units who coordinates the activity programme. Group activities are voluntary and developed by the activities staff. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. The service has a van which is used for resident outings. The group activity plans were displayed on noticeboards around the facility.  There is one programme for the rest home and hospital residents and residents attend which activity they wish to attend. A separate programme is provided in the psychogeriatric units, however, residents often join (under supervision) concerts and events with the other residents. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept to ensure all such residents are included. All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff. The resident files reviewed included a section of the care plan was for activity and has been reviewed six-monthly. Residents interviewed spoke positively of the activity programme with feedback and suggestions for activities made via meetings and surveys. Two family members interviewed with loved ones in the psychogeriatric unit spoke highly of the activity staff and the varied programme provided. Two hospital residents interviewed stated that they attend the weekly “stroke and senior moments club” in the community and that activity staff organise transport to and from the club each week. The organisation has an occupational therapist that oversees the activity programme and is available for activity staff to discuss recreational programmes and provides education for activity staff twice a year. The residents are maintaining links with the community and continuing activities they participated in outside of the facility. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the residents’ files reviewed, all initial care plans were documented and evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed but not all care plans were evaluated or updated following a change in health condition (link 1.3.6.1). The GP reviews the residents at least monthly or earlier if required. Evidence of monthly GP reviews were seen in all residents’ files sampled. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes (link 1.3.6.1). A multidisciplinary team meeting is conducted six-monthly for each resident and involves all relevant personnel. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry February 2017). The facility is accessible to meet the mobility needs of residents with a disability. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.  There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There are six hospital residents requiring the use of bed rails as restraint and one hospital resident is environmentally restrained as they cannot use the keypad exit or read the code number written clearly at the keypad. There are two residents in the psychogeriatric unit who require the use of a lap-belt as a restraint. There were two hospital residents requiring the use of an enabler (bedrail). Use of an enabler is voluntary. An assessment for restraint/enabler use and consent form were evidenced completed in two restraint and one enabler file reviewed. The care plans reviewed documented the use of enabler or restraint and contained appropriate interventions. However, monitoring of enabler and restraints when in use were not always evidenced to be consistently documented (link 1.3.6.1). |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an annual education schedule that is being implemented, however attendance was observed to be low. In addition, opportunistic education is provided by way of toolbox talks. Toolbox talks are held on a regular basis and staff are encouraged to participate. A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained – competency register sighted. | Attendance at education sessions was evidenced to be low. Examples include: Nutrition and hydration -June 2016; 8 of 94 staff; Restraint -July 2016 12 of 94 staff; Skin care best practise --September 2016 13 of 94 staff; and accident and incident reporting -February 2016 10 of 94 staff attended. This finding has been rated as a low risk as opportunistic education is provided via toolbox talks and competencies are completed. | Ensure sufficient staff attend education and training sessions.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The services medication management policy outlines the policies and practices to be followed in relation to medication management. Staff interviewed who administer medication could describe safe medication management and administration practices (observed). Medication is stored in locked trolleys in locked rooms in each clinical area. There is a process in place for the reconciliation of medication including the checking of new medication packs and for the return of medication to pharmacy. The medication fridge temperatures are required to be checked and recoded daily however medication fridge temperatures had not been consistently recorded. | Medication fridge temperatures were not consistently documented in three of three medication fridges in use. | Ensure that medication fridge temperatures are consistently record as per policy.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | There are policies and procedures documented for the food service. Kitchen audits are completed as part of the quality management system, Previous audits have generated corrective actions in relation to kitchen cleaning and these corrective actions have been signed out as completed. On the day of audit the kitchen appeared clean, however, not all scheduled cleaning had been consistently documented as completed. The kitchen staff undertake food preparation in the kitchen. On the day of audit, food preparation for the following day was stored on a desk used by the kitchen manager in an adjoining room. | i) The kitchen cleaning schedules sighted, did not evidence that the required cleaning had consistently been documented as noted on the corrective action reports.  ii) The food premixed and prepared for the next day’s baking (dry goods and butter) was removed from the kitchen food preparation area and was being stored for use the next day on the kitchen manager’s desk in an adjoining room. | i) Ensure that all scheduled cleaning is completed and cleaning schedules are fully documented.  ii) Ensure that all food preparation and food storage complies with recognised food safety practices.  90 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | The registered nurse completes a nutritional profile for all new residents and sends a copy of this to the kitchen. The kitchen manager had been off for a period of leave and on the day of audit was in the process of implementing the Bupa system for communicating to kitchen staff the resident’s specific dietary requirements. The kitchen manager was unaware of the two residents requiring additional nutritional support following weight loss. | The kitchen manager interviewed on the day of audit was unaware of the two residents (one hospital, one psychogeriatric) requiring support following documented weight loss. | Ensure that kitchen staff are aware of the special dietary requirements for all residents.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | In the files sampled, interRAI assessments were completed for all residents requiring an interRAI assessment but not all interRAI assessments were completed in the required timeframes. Long-term care plans were completed within 21 days of admission and reviewed by the registered nurse. Long-term care plans were reviewed but not all care plans had been reviewed in the required timeframes. | i) One of seven files reviewed (hospital) did not have the interRAI assessment completed within 21 days of admission.  ii) One of seven files reviewed (rest home tracer) did not have the long-term care plan reviewed six-monthly. | i-ii) Ensure that all interRAI assessments and long-term care plan reviews are completed in the required timeframes.  90 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 | The RN reviews information gathered from assessments, monitoring charts, observations and interviews with residents, staff and families to develop the care plan. Not all interventions for assessed care needs were included in the care plan and not all interventions documented had been written in sufficient detail to guide the care staff. Not all interventions currently being implemented were documented in the care plans. While monitoring charts were being utilised and staff could describe monitoring, not all the required monitoring was fully documented. Interventions noted on the accident and incident forms and by the GP and the wound care specialist nurse were not all transferred to the long-term care plan. | i)Interventions were not documented or documented in sufficient detail to guide care staff for: a) one hospital resident on insulin had no diabetic emergency management interventions documented and no intervention documented for the management of depression, care of the urostomy or a urinary tract infection, b) one psychogeriatric resident had no specific interventions documented for the monitoring required for signs of depression, or possible side effects of a recent change to medication (midazolam), c) one hospital (respite) resident had no interventions documented to manage all current identified needs, d) one hospital resident (YPD) with history of seizures had no interventions documented for the management of seizures, e) one psychogeriatric resident with weight loss had no interventions documented for the weight loss and f) one rest home resident with history of absconding had no interventions documented to manage the risk at the time of the incident (rest home tracer).  ii) Interventions’ in use were not documented in the care plan for a) one hospital resident using an air mattress, roho cushion and gel booties (hospital tracer), b) one psychogeriatric resident wearing a full body suit, c) one hospital (respite) resident using a sensor mat, and e) one hospital resident (YPD) using a half door to prevent unwanted visitors entering the bedroom.  iii) Monitoring was not consistently documented for a) one hospital resident using an enabler and one hospital resident using a restraint, b) one rest home and one psychogeriatric resident(tracer) on intentional rounding and on food and fluid monitoring.  iv) Interventions requested by a GP and/or wound care specialist nurse were not transferred to the long-term care plan for a) one hospital resident (tracer) with multiple pressure injuries and b) one respite (hospital) resident for lying and standing BP.  v) Interventions noted on eight accident/incident forms were not transferred to the care plan for one hospital respite resident. | i)-ii) Ensure that interventions are documented for all assessed care needs and in sufficient detail to guide care staff.  iii) Ensure that monitoring is consistently documented as detailed in the care plan.  iv) Ensure that all interventions requested by allied health care and noted on accident and incident forms are transferred to the care plan.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.