# Bupa Care Services NZ Limited - Merrivale Rest Home

## 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](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:** Merrivale Rest Home

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

**Dates of audit:** Start date: 13 December 2016 End date: 14 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:** 64

# 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 Merrivale provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 66 residents. During the audit, there were 64 residents.

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

The care home manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse).

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service, including residents that require hospital/medical, dementia and rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to Merrivale. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

The facility has embedded the interRAI assessment protocols within its current documentation.

The service has achieved two continual improvement ratings relating to good practice and implementation of the quality system.

This audit identified improvements required around aspects of resident care plans, monitoring of medication fridge temperatures and food labelling and storage.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Bupa Merrivale endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

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

Services are planned, coordinated and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. The integrated residents’ files are appropriate to the service type.

## 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 low risk. |

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 a 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/nurse practitioner.

An activities programme is implemented separately for the rest home, hospital and dementia residents. 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. Nutritious snacks are available 24/7 in the dementia unit.

## 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. |

Chemicals are stored securely throughout the facility. 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

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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. |

Enablers are voluntary and the least restrictive option. There were no residents who required enablers or restraints during the audit.

## 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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. 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** | 1 | 41 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 2 | 88 | 0 | 3 | 0 | 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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (fifteen caregivers, one enrolled nurse, four registered nurses, two unit coordinators, one activity coordinator, one cook, the clinical manager and care home manager), reflected their understanding of the key principles of the Code. |
| 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 | There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the eight residents’ files reviewed (two dementia, three hospital and three rest home which included one respite resident). Advance directives if known were on the residents’ files. Resuscitation plans for competent residents were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions. An informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had been provided.  Long-term resident’s files reviewed had a signed admission agreement or were in the process of being signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information about the national Health and Disability Advocacy service’ is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility in three languages. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. They have also created ongoing relationships with community groups that come to Merrivale, for example the Whangarei quilters association.  Animal programmes such as the rescue pets, guide dogs and visits from the local police dog and constable have ensured residents have access to animals as therapy and form community connections.  Resident and relative meetings are held bi-monthly. Family members from the dementia unit are facilitated to attend the local Alzheimer’s Society meetings. Monthly newsletters are provided to residents and relatives. |
| 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.  Six complaints were reviewed in their entirety and reflected evidence of responding to complaints in a timely manner with appropriate follow-up actions taken. All six complaints were signed off by the care home manager as resolved. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission.  Discussions relating to the Code are held during the resident/family meetings. All six residents (three rest home -including one person receiving respite care and three hospital) and four relatives (one hospital and three dementia) interviewed reported that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| 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 | Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.  All resident files reviewed evidenced that cultural and/or spiritual values and individual preferences are identified. |
| 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 | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Five residents who identify as Māori are living at the facility. Two Māori residents interviewed (rest home) confirmed that Māori cultural values and beliefs are being met. There is a partnership with the Pihiaweri and Ngaratunua Marae and residents are able to attend. There are links to the local Ratana Church and residents are able to attend services.  Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. All residents and relatives interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs.  All care plans reviewed included the resident’s spiritual and cultural needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.  Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two caregivers from the dementia unit could describe how they build a supportive relationship with each resident. Interviews with three families from the dementia unit confirmed that staff are reassuring and assist to relieve resident’s anxiety. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. A house GP visits the facility two days a week and provides an after-hours service. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed was satisfied with the level of care that is being provided.  The service receives support from the district health board, which includes nurse specialist’s visits. Physiotherapy services are provided on-site four hours per week with the support of a full-time physiotherapy assistant. A dietitian is also available for urgent consultations. There is a regular in-service education and training programme for staff. A podiatrist is on-site every six weeks. The service has links with the local community and encourages residents to remain independent.  Bupa has established benchmarking groups for rest home, hospital and dementia services. Bupa Merrivale is benchmarked against the rest home, hospital and dementia services data. If the results are above the benchmark, a corrective action plan is developed by the service.  The service demonstrated a number of examples of good practice including not using any restraint. |
| 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. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. 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.  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 Ministry of Health ‘Long-term Residential Care in a Rest Home or Hospital – what you need to know’ is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.  An introduction to the dementia 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. |
| 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 Merrivale provides hospital (geriatric and medical), rest home and dementia level care for up to 66 residents. There are three dedicated respite beds (two dual-purpose and one hospital). On the day of audit there were sixty-four residents including one hospital and one rest home resident receiving respite care. There were 21 of 23 residents in rest home beds, and 28 of 28 hospital residents and 15 of 15 residents in the dementia care beds.  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.  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 Merrivale quality goals.  The service is managed by a care home manager who is a registered occupational therapist. The manager has experience working in allied health leadership roles with the over 65-year age group within the DHB. She is supported by an experienced clinical manager/registered nurse (CM) who has been in the role for six weeks. The clinical manager has previous experience working as a clinical nurse specialist (rehabilitation) in a DHB hospital. The care home manager and CM are supported by a Bupa Regional Manager, Bupa relieving care home manager and unit coordinators/RNs. The relieving Bupa care home manager and regional manager attended the audit. The care home manager and CM have maintained over eight hours annually of professional development activities related to managing an aged care service. |
| Standard 1.2.2: 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 the temporary absence of the care home manager, the clinical manager or Bupa relieving facility manager covers the care home manager’s role. |
| 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 injuries, 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.  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.  As a result of data analysis completed on falls, the facility has implemented a number of quality improvements. Falls prevention strategies include: the recent formation of a falls focus and skin tear prevention group, manual handling refresher education for all care staff, ensuring transfer plans are current, intentional rounding, use of senor mats, analysis of falls events including times and location of falls and links to any infection/period of illness and the identification of interventions on a case-by-case basis to minimise future falls.  In response to resident survey feedback the facility has recently implemented a quality improvement project around the activity programme which has included residents attending the monthly Mix and Mingle programme at the local library, involvement with the local community Christmas parade and Quilters Association. |
| 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. |
| 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 | Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files reviewed (two RNs, seven caregivers, one activities coordinator) 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 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.  A total of nine caregivers are employed to work in the dementia unit with seven having completed their national dementia qualification. Two caregivers are in the process of completing their qualification and have been employed for less than six months.  Thirty-three per cent of the total staff have attained at least one Bupa Personal Best certificate.  A total of 50% of caregivers have attained a Careerforce qualification with the remaining 50% of staff currently enrolled on Careerforce education programmes.  Registered nurses are supported to maintain their professional competency. Eight registered nurses and four enrolled nurses are employed. Six of eight registered nurses have completed their interRAI training. There are a number of implemented competencies for registered nurses including (but not limited to) medication competencies and wound care.  The new clinical manager has a background in education and is promoting the uptake of the Bupa PDRP programme to the registered nursing team.  Assistance with numeracy and literacy is available and is provided to those staff that request or need assistance. |
| 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 (RN) Mon - Fri. There are two unit coordinators (RNs) in the dementia and hospital units. An enrolled nurse is the unit coordinator in the rest home. Unit coordinators work Mon-Fri. The clinical manager oversees the rest home and provides RN input. This equates to two days per week but she is available Monday to Friday. The hospital RN covers afternoons and night duty. Registered nurse cover is provided 24 hours a day, 7 days a week. There is one registered nurse on night duty. RNs 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 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are 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. Residents' files are protected from unauthorised access by being held securely in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts held in a separate folder. |
| 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. The admission agreement reviewed aligns with the service’s contracts. Eight 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’s check all medications on delivery against the medication profile and any pharmacy errors are 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. The standing orders have been approved by the GPs annually and meet the legislative requirements for standing orders. There were two rest home residents self-medicating on the day of audit. Self-medicating competency, three-monthly reviews and monitoring were in place. The medication fridge temperatures have not been consistently recorded.  Sixteen medication charts were reviewed (six rest home-including one respite resident, six hospital and four dementia). Photo identification and allergy status was on all 16 charts. All medication charts had been reviewed by the GP at least three-monthly, including the resident admitted for respite. Sixteen of sixteen resident medication administration-signing sheets corresponded with the medication chart.  Anti-psychotic management plans are used for residents in the dementia units when medications are commenced, discontinued or changed. The GP reviews the anti-psychotic management plans at least monthly or earlier and if required, makes a referral to the Psychiatric Older People services.  It was identified that the service was managing the medication system very well with few errors using a complex paper based system. |
| 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 | Bupa policies and procedures are available. The kitchen manager (chef) oversees the food services and is supported by a cook and kitchen hands. The national menus have been audited and approved by an external dietitian. The main meal is served at lunchtime. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in bain-maries or hot boxes to the kitchenettes in each area where they are served. The kitchen manager 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.  End cooked food temperatures are recorded on each meal daily. Serving temperatures from bain-maries are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges and freezer temperatures are monitored and recorded daily. Not all foods stored in communal resident food fridges were dated. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.  Food services staff have complete on-site food safety education and chemical safety.  There are specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals. There are nutritional snacks available in the dementia unit 24 hours.  Residents have the opportunity to provide feedback on the menu and food services through the resident meeting, which the chef attends. Meeting minutes are available to the food services team. |
| 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 | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was 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 and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour and wound care were completed according to need. InterRAI initial assessments and assessment summaries were evident in printed format in all long-term resident files. The information obtained through the assessment processes is reflected in the care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Care plans reviewed demonstrated service integration and input from allied health. The resident care plans sampled were individualised, however not all care plans included all identified care needs. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. The residents in the dementia unit had an activity care plan documented to cover the 24-hour period.  Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The care plans reviewed included interventions that reflected the resident’s current needs with the exceptions documented in (link 1.3.5.2). When a resident’s 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 a three-day urinary continence assessment, bowel management and 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 and RNs interviewed state there is adequate continence and wound care supplies.  Wound assessment, wound management and evaluation forms and short-term care plans were in place for twelve of twelve wounds care files sampled (hospital - four skin tears and two stage II facility-acquired pressure injuries, rest home -two surgical wounds and dementia one skin tear and one graze).  Behaviour monitoring charts are used daily for any residents that exhibit challenging behaviours.  Monitoring charts were sighted included (but not limited to): vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring. |
| 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 service employs three activity coordinators to deliver a separate programme across the three service levels Monday to Friday. A volunteer provides craft activities on a Sunday. Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings.  Activities meet the abilities of the rest home, hospital and dementia residents. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. Activities were observed to be delivered simultaneously in the rest home, hospital and dementia unit. Residents in the dementia unit are encouraged (where appropriate) to join in activities in the other areas of the care home (observed). There is an activity programme in place that covers the 24-hour period for residents in the dementia unit.  The activity coordinator who works in the dementia unit is an enrolled nurse and has completed the dementia unit standards. The activity staff all have a current first aid certificate.  Residents are encouraged to maintain links with the community with visits to the local shops, Maraes and other community groups. There are regular entertainers to the home and residents go on regular outings and drives. The service has two vans and both have a wheelchair hoist.  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 long-term care plan and is reviewed at the same time as the care plan in all resident files reviewed.  Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. A quality improvement project around activities has been implemented as a result of resident feedback (link to 1.2.3.) |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by registered nurses’ six-monthly. One rest home resident admitted for frequent periods of respite had the care plan evaluated and updated with each subsequent admission. 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 (link 1.3.5.2). The multidisciplinary review involves the RN, GP, physiotherapist, 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. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| Standard 1.3.9: Referral To Other Health And Disability Services (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. | FA | 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 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 clinical manager, unit coordinators and RNs identified that the service has access to a wide range of support either through the GP, 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. | FA | There is a chemical substance safety and waste management policy. Management of waste and hazardous substances is covered during orientation of new staff. Chemicals are stored safely in a locked cupboard. Safety data sheets and product wall charts are available. All chemicals were labelled correctly. 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. There is a chemical spills kit available. Staff have attended chemical safety training. |
| 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 1 June 2017. The building has two levels on a sloping site with lift access between the floors. Both levels have outdoor access. There is a retirement village located on the first floor and all care is delivered on the second floor.  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. The dementia unit has a safe indoor and outdoor environment with a deck, seating, shade and raised gardens. This is a no smoking site.  Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a 52-week planned maintenance programme in place. Hot water temperatures are monitored weekly in resident areas and are within the acceptable range. All medical equipment sighted was calibrated in November 2016.  The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.  Feedback from the 2015 resident satisfaction survey resulted in a quality goal and plan established from the resident feedback which included: improving the environment with outdoor shade sails, furniture, revamp of gardens, makeover of rest home dining room where residents have chosen furnishings and wall prints, resealing the carpark and cleaning up the two gazebos. |
| 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 bedrooms have access to hand basins. The bedrooms without ensuites have shared toilet and shower facilities located near the bedrooms. There are adequate numbers of communal toilets and shower rooms. 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 | All bedrooms are single and 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 | Communal areas within the facility include open plan lounges and dining areas in each unit. There is a family room within the facility. The communal areas are easily accessible for residents. There are quiet seating areas available in each unit.  Residents (as able) were observed to be moving freely with the use of mobility aids. Furniture was well arranged to facilitate this. All dining rooms and lounges can accommodate specialised lounge chairs. Seating and space is arranged to allow both individual and group activities to occur in each area.  Residents in the dementia unit were observed to mobilise freely between the lounge and secure garden areas. |
| 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 laundry persons on duty for ten hours a day, seven days a week. 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.  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 occur 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 and battery backup. 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 and security patrols are conducted by a security firm 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 heat pumps/air conditioning throughout and enclosed wood burner effect electric fires in the rest home and hospital lounges. 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 and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The clinical manager is the infection control coordinator and is responsible for infection control across the facility. The committee and the Bupa governing body in conjunction with Bug Control, is responsible for the development of the infection control programme and its review. The infection control programme is well established at Bupa Merrivale. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners and the Bupa quality & risk team. |
| 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 organisation. | FA | There are adequate resources to implement the infection control programme at Bupa Merrivale. The infection control (IC) nurse has maintained best practice by attending an external infection control conference and participating in training at the DHB. The infection control team is representative of the facility. External resources and support are available through the Bupa quality & risk team when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| 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 defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to): outbreak management (September 2016) and infection prevention & control and handwashing in November 2016. The infection control coordinator has access to the Bupa intranet with resources, best practice guidelines and group benchmarking. A number of toolbox talks have been provided including (but not limited to) preventing UTIs and handwashing. |
| 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 and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and the infection control practitioner at the DHB that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.  Infections statistics are included for benchmarking. Corrective actions are established where trends are identified. The facility has managed two outbreaks since the last audit. The outbreak events were reviewed and corrective action were implemented where required. |
| 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. At the time of the audit, the service had no residents using enablers or restraints. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  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 service’s 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. 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 recorded as per policy.  60 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Frozen food temperatures are checked on arrival from the supplier and before hot food leaves the kitchen at each meal service. In the main kitchen, the chiller and freezer temperatures are checked daily. Dry goods and fresh vegetables are correctly stored. Food stored in the main kitchen chiller was correctly dated and labelled. Resident food stored in the kitchenettes in each area, were not labelled or dated. | The food fridges in the kitchenettes in the rest home, hospital and dementia areas did not have date labels on the resident food. | Ensure that all food stored for residents is correctly labelled and dated.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Care plans were developed by the registered nurse and were based on information gathered through the assessment process. One hospital resident on monthly weights evidenced a consistent weight loss over a 12-month period and had no interventions implemented or a care plan documented for the weight loss. A weight management care plan was documented on the day of audit.  Care plans were documented for the management of behaviours triggers, interventions and de-escalation techniques including activities over a 24-hour period. However, one dementia resident did not have a care plan documented for the interventions implemented to manage a sudden change in behaviour. | i) One hospital resident did not have a care plan documented for the management of consistent weight loss (7kg in total since January 2016); and  ii) One dementia resident (tracer) did not have a care plan documented for a sudden change in behaviour. | i-ii) Ensure care plan interventions are documented to address all assessed care needs.  90 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.  A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts.  Bupa has a bi-monthly clinical newsletter called Clinical Bites, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Registered nurse interviewed at Merrivale could describe this. Competencies are completed for key nursing skills. Registered nurses regularly access training, including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions.  Bupa newsletters are available for residents and relatives at Merrivale. Merrivale also provides monthly newsletters for residents and relative. The service identified an improved communication to families, including mail out of invitations to resident /whānau meetings and mail outs of minutes. | Bupa has robust quality and risk management systems and these are implemented at Merrivale, supported by a number of meetings held on a regular basis. Quality improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Merrivale through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. All new caregiving employees undertake National Certificate of Foundation skills as part of their three-month orientation.  A 35% turnover in staff YTD at Merrivale and the temporary loss of a Careerforce assessor has resulted in 35% of staff qualified at level 3 with the remainder of the new staff enrolled. They have now appointed two Careerforce assessors and enrolments and training has recommenced in October 16.  Merrivale is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans (CAP) are established when above the benchmark. The service has set up a falls and skin tear focus group to refocus their staff on reducing falls and with a focus on correct manual handling, with a secondary focus on skin tears. They have identified over reporting with skin tears and staff have been retrained to identify. Toolbox talks have been routinely completed that link to benchmarking indicators in each of the three areas at Merrivale. A post falls pack with all assessments have been compiled to ensure time and accurate assessment post fall. Quality action forms are also established for areas that staff/management identifies as requiring improvement and these are evaluated for effectiveness. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six -monthly or annually as designated by the internal auditing programme schedule.  Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (e.g., quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited.  Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Merrivale and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.  There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Merrivale is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data and quality goals where opportunities for improvement are identified. | Merrivale is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc.  Example: Falls were noted to be high in 2015 and Merrivale was above the national average and KPI. 2016 quality goals were developed around “Reducing incidents of resident slips/trips and falls in the hospital by 20% from 2015’s of 10. 3 per 1000 bed days to 8 per thousand bed days. The service commenced a Falls Focus group in light of their high falls. Falls prevention strategies were implemented including (but not limited to): toolbox talks have been completed with staff about answering call bells, toileting schedules maintained at times analysed as being high risk times and ensuring sensor mats are in place and working. Monitoring and review of transfer plans was completed. Over half of the transfer plans have been updated and the unit coordinators are leading completion. On evaluation of the effectiveness of these measures, they noted a drop in falls incidents in the hospital July and August. Other corrective actions and strategies have been implemented where clinical indicators were above the benchmark.  From 1st July to end of September 18, falls were recorded with a range of 3-9 per month compared to 28 falls in the previous quarter with a range of 7-11. At the end of quarter 2, they had falls rate of 12.6 patient bed days and this quarter’s results show a reduction in rate to 10.3. So, while falls have decreased from both quarter 1 and 2, the quality goal continues to be a work in progress.  Other quality initiatives have been established around (i) decreasing skin tears for residents in hospital by 25% from 2015 of 5.5 ptbd to 4.1ptbd. Strategies have been implemented and evaluations to date show. From the 1st July to the end of September (3rd quarter) there were 17 skin tears recorded with a range of 3-7 compared to the 2nd quarter when there were 24 with a range of 6-9 so there has been a reduction seen.  (ii) decreasing the number of pressure injuries in hospital level residents by 50% from 2015’s of .6 ptbd to .3. Strategies have been implemented and evaluations to date show from 1st July to end of September there were two pressure injuries, none in July or August, two in September (stage I and stage II).  As at the end of Quarter 2 they had an API rate of .7 compared to national average of 1.0. They have maintained the rate of PI from 2015, but the quality goal is still being worked towards achieving. |

End of the report.