# Bupa Care Services NZ Limited - Parklands Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Parklands Hospital

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)

**Dates of audit:** Start date: 7 February 2017 End date: 8 February 2017

**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:** 130

# 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 Parklands provides hospital (medical and geriatric) and psychogeriatric level care for up to 134 residents. During the audit, there were 130 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).

This certification audit identified that improvements are required in relation to attendance at staff training, care planning, completion of clinical monitoring forms, medication management and restraint monitoring.

## 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. |

Staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Code of Health and Disability Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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

The care home manager is a registered nurse. She is supported by a clinical manager, unit coordinators, registered nurses, caregivers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Resident and family meetings are held and residents and families complete an annual satisfaction survey. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. An education and training programme is established with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate cover for the effective delivery of care and support.

## 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. |

There is a comprehensive admission package available prior to or on entry to the service, including individual information for the hospital and psychogeriatric units. Residents’ 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. Residents’ files include three monthly reviews by the nurse practitioner or 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 complete education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

An integrated activities programme is implemented that meets the needs of aged care residents. The programme includes community visitors and outings, entertainment and activities. All food and baking is done on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans.

## Safe and appropriate environment

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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. |

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

All bedrooms are single occupancy with adequate numbers of toilets and showers. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible and secure for the units that require this.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

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

Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. On the day of audit there were twenty residents using restraint and two residents with an enabler. Restraint management processes are being implemented.

## 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 officer (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 officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 3 | 2 | 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 Code of Health and Disability Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with the care home manager/registered nurse (RN), clinical manager/RN and twenty-two care staff (eight caregivers [four on the am and four on the pm shifts covering the hospital and psychogeriatric units], six RNs, three physiotherapy staff, five activities staff) confirmed their familiarity with the Code. Interviews with two hospital level residents and nine relatives (six hospital and three psychogeriatric) confirmed that the services being provided are in line with the Code. The Code is discussed at resident and staff meetings. |
| 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 twelve residents’ files reviewed (six hospital and six psychogeriatric). 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 | There is a policy that describes the role of advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer and includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family with advocacy information. Advocacy support is available if requested. An external advocate for one resident was interviewed and confirmed that she was contacted by the service to advocate for the resident.  Interviews with staff, residents and relatives confirmed that they were aware of advocacy services and how to access an advocate. The complaints process includes informing the complainant of their right to contact an advocacy service for support. |
| 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 are encouraged to be involved in community activities and maintain family and friends networks. Care staff interviewed confirmed that residents are encouraged to build and maintain relationships. Visiting can occur at any time. Community links are in place with local churches, nearby schools and entertainers. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy describes the management of the complaints process. There is a complaint form available. Information about complaints is provided on admission. A suggestions box is held at reception. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  A complaints register is being maintained. Fourteen complaints were lodged in 2016, which included both verbal and written complaints. All complaints held in the register included evidence of an investigation, corrective actions (where indicated) and resolutions. One complaint lodged with HDC in 2014 around resident cares and medication management is still ongoing with HDC. An action plan was submitted to HDC in January 2017 with evidence that correctiev actions have been implemented including providing RN and enrolled nurse (EN) education. The geriatrician interviewed during the audit advised he was conducting some education sessions around the outcomes from the complaint.  Complaints are linked to the quality and risk management system (link 1.2.3.6). Discussions with residents and relatives confirmed that issues are addressed promptly and that they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters displaying the Code. The service is able to provide information in different languages and/or in large print if requested. On entry to the service the care home manager or clinical manager discuss the Code with the resident and family/whānau. Information relating to the Code is given in the information pack to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. During the audit, staff demonstrated gaining permission prior to entering residents’ rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents’ cares. Residents and family members interviewed confirmed that staff promote the residents’ independence wherever possible and that residents’ choices are encouraged. Residents’ rooms share full ensuites. Care staff knock before entering. Privacy signage was missing for a selection of communal toilets in the hospital units. This was addressed at audit. There is an abuse and neglect policy that is implemented. |
| 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 has established Māori cultural policies to help meet the cultural needs of its Māori residents. Bupa has developed Māori Tikanga best practice guidelines. The service has established links with a local Māori advisor. Staff training includes cultural safety. A cultural assessment is completed during the resident’s entry to the service.  There was one resident who identified as Māori. An interview with the resident confirmed that their cultural needs were being met. |
| 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 has established cultural policies aimed at helping to meet the cultural needs of the residents. All residents and relatives interviewed reported that they were satisfied that the residents’ cultural and individual values were being met. Information gathered during assessment including residents cultural beliefs and values is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. |
| 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 orientation to the service and is signed by the new employee (sighted in all 12 employees’ files audited). Professional boundaries are defined in job descriptions. Interviews with staff 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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice was evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (eg, wound care, mental health) and staff education and training. Physiotherapy services are provided for 10 hours per week with additional support provided by two designated physiotherapy assistants. There is an education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community which includes (but is not limited to) advocacy, and entertainers.  Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services and benchmarking data is available at Parklands. Parklands is currently benchmarked in two areas (hospital and psychogeriatric).  Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia, (eg, mortality and pressure incidence rates and staff accident and injury rates). Benchmarking of some key indicators with another NZ provider was commenced 10 January 2017. Benchmarking data supports initiative development and there were a number at Parklands where Quality Indicator - Corrective Action Plans have been established due to benchmarking analysis. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff of their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.  Twenty incidents/accidents forms selected for review indicated that family were informed. Family communication sheets are also held in residents’ files. Families interviewed confirmed they are notified of any changes in their family member’s health status.  Interpreter services are available if needed. There was one resident who was Russian-speaking. Family are utilised in the first instance with signage to assist. |
| 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 Parklands provides psychogeriatric and hospital level care for up to 134 residents and is certified for hospital – medical. There were 130 residents in the facility on the day of audit (70 hospital and 60 psychogeriatric). One of the hospital level residents was on a palliative care contract.  There is an overarching Bupa business plan and risk management plan. Additionally, Bupa Parklands has developed annual quality and health and safety goals. Goals are reviewed regularly in the quality meetings and are updated on the goal sheet quarterly (at a minimum).  The care home manager is an RN who has been in her role since October 2015. Previous to her current role she worked for Bupa in management roles for nine years. The care home manager is supported by a clinical manager (registered nurse) who oversees clinical care. The clinical manager has been in the post for eight years. The management team is supported by the wider Bupa management team including a regional operations manager.  The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles. |
| 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 | In the absence of the care home manager, the clinical manager is in charge. For extended absences, a Bupa relieving care home manager is rostered. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the managers and 24 staff (22 care staff, maintenance staff and kitchen manager) reflected their understanding of the quality and risk management systems.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility 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. Policies and procedures include reference to InterRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.  An internal audit programme is in place. In addition to scheduled monthly internal audits, a facility health check is conducted six monthly by an external Bupa representative. Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed for each resident involved. Quality data and results are documented in the quality meetings but are not regularly communicated to staff in staff meetings. Corrective actions are implemented where opportunities for improvements are identified (eg, benchmarked data exceeds acceptable limits). Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented.  The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The care home manager is the health and safety officer. Eight health and safety representatives (interviewed) are either appointed or elected by staff and meet quarterly. Staff undergo annual health and safety training which begins during their orientation, although attendance rates are below 50% (link 1.2.7.5). Staff are encouraged to enrol in the Bupa Bfit staff health and safety programme. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. Bupa has been awarded tertiary level ACC workplace safety management practice (expiry 31 March 2017).  Strategies are implemented to reduce the number of falls. This includes, but is not limited to ensuring call bells are placed within reach, the use of sensor mats, regularly checking residents at risk of falling, encouraging participation in activities, and physiotherapy input. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.  Improvement Note: Quality data discussed and analyses at quality meetings (eg, complaints, internal audit results, accidents and incidents) are posted in the staffroom but are not communicated to staff in staff meetings. Staff who do not attend meetings do not sign that they have read the meeting minutes. |
| 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 | There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all twenty accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations.  Discussion with the care home manager confirmed her awareness of the 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. | PA Low | There are human resource management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of practising certificates are retained. Twelve staff files reviewed (eight caregivers, two RNs, one kitchen manager, one physiotherapy assistant) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions. Annual performance appraisals are behind schedule.  The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Caregivers complete an aged care education programme as part of their induction, which meets the New Zealand Quality Authority (NZQSA) requirements. Sixty-five caregivers (97%) are enrolled in Careerforce and are working through these modules.  The education programme being implemented includes in-service training, a number of competency assessments, impromptu tool box talks and study days. Attendance at staff mandatory training is frequently below 50%; however toolbox talks are regularly completed (26 in 2016).  Registered nurses have opportunities available to attend training, one RN attended Bupa emerging leaders course, two RNs attended “Walking in another’s shoes” dementia education with CDHB, two RNs attended postgraduate studies through Otago University and two RNs attended short courses at Ara on infection control and wound assessment and management.  RNs recently attended compulsory education around communication, policies and procedures, medication management, and professional standards for documentation in response to a complaint that was lodged with HDC (link 1.1.13). The kitchen manager has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on site. Chemical safety training is included in staff orientation and as a regular in-service topic.  RNs are in the process of completing their professional development recognition portfolio (PDRP). Ten of twenty-seven RNs have completed their InterRAI training. The care home manager, clinical manager and staff occasionally attend external training including sessions provided by the district health board. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale and skill mix policy is in place. Staff rostered on to manage the care requirements of the resident meets contractual requirements. Both the care home manager and clinical manager hold current practising certificates and work full time Monday - Friday. The care staff are rostered for four days on and four days off.  RN staffing meets contractual requirements for hospital and psychogeriatric levels of care. Oversight is provided by the clinical manager/RN.  Hospital level: Residents are based in three units (kowhai, ngaio, and matai). Two unit coordinators/RNs (one for kowhai/ngaio and one for matai) are rostered for the hospital level residents although there has been one unit coordinator vacancy since December 2016. In addition, one staff RN covers kowhai/ngaio (occupancy 36) from 0700 – 1500, 0930 – 1800 and 1500 – 1100 and one staff RN covers matai (occupancy 34) for the same hours. One RN covers all three hospital units during the night shift.  Psychogeriatric level: Residents are based in three units (kauri, rata and rimu) which are linked to each other but have separate security systems. One unit coordinator is rostered Monday – Friday for the three units. All three units were full with 20 residents in each unit. An RN or EN covers each of the three units on the am and pm shifts and one RN covers all three units during the night shift.  Adequate numbers of caregivers are rostered in the hospital and PG units for residents’ cares with three additional caregivers rostered on the am and pm shifts to assist in meeting the fluid needs of the residents. The care home manager reported that extra staff can be called on for increased residents' requirements. Activities staff are rostered seven days a week.  Interviews with staff, residents and family members identified that staffing was 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. 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 caregiver or RN. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are stored on the electronic medication management system. |
| 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 overarching Bupa policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy. Information gathered on admission is retained in residents’ records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry including specific information regarding the psychogeriatric unit. The admission agreement reviewed aligns with the service’s contracts. Twelve admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.  All psychogeriatric residents had an assessment completed for this level of care. |
| 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 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 Moderate | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication rooms in six areas were clean and well organised. The medication fridges have temperatures recorded weekly and these are within acceptable ranges.  Registered nurses are responsible for the administering of medications and have completed annual medication competencies and annual medication education. Caregivers who act as second checker have also completed medication competencies. The service uses an electronic medication management system.  Twenty-four electronic medication charts were reviewed (12 hospital and 12 psychogeriatric). Photo identification and allergy status were on all 24 charts. All medication charts had been reviewed by the GP at least three monthly. Not all resident medication administration signing sheets corresponded with the medication chart.  Anti-psychotic management plans are used for residents using anti-psychotic medications when medications are commenced, discontinued or changed. The general practitioner reviews the anti-psychotic management plans for residents with stable behaviours and a psychogeriatrician reviews the management plans for residents with acute changes in behaviour. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The kitchen manager oversees the food services and is supported by kitchen staff on duty each day. The national menus have been audited and approved by an external dietitian. The main meal is at lunchtime. All baking and meals are cooked on site in the main kitchen. Meals are delivered in a bain-marie to each kitchenette 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. There is evidence that additional nutritious snacks are available over 24 hours in all units.  End cooked food temperatures are recorded on each meal daily. Serving temperatures from the bain-marie are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.  Food services staff have completed food safety education and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry were declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility has embedded the InterRAI assessment protocols within its current documentation. Bupa assessment booklets on admission and care plan templates were completed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all files. Files reviewed across the service identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, wound care and restraint were completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | All resident care plans sampled were resident centred and included support needs and interventions, however not all care plans were updated as resident status changed. Residents and family members interviewed confirm they are involved in the development and review of care plans.  Six of six psychogeriatric resident files reviewed identified current abilities, level of independence and specific behavioural management strategies. Behaviour monitoring charts were in use, as appropriate for escalation in behaviours.  Short-term care plans were in use for infections and wound care and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | There is specialist input into resident’s well-being in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the care team.  Residents and families interviewed reported their needs were being met. Family members interviewed praised the service, the care staff and the management team. 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.  Very comprehensive wound assessment, wound management and evaluation forms and short-term care plans were in place for wounds. All wound care plans included a short-term care plan and written progress notes to assist review and evaluation of the wound.  On the day of audit, there were eight wounds documented for the three hospital units. The wounds included; four skin tears, one sinus wound, one stage-one, one stage-two and one stage-three pressure injury. The community wound care specialist had reviewed the pressure injuries and would care plans reflect the specialist input.  The three psychogeriatric units documented a total of ten wounds (four skin tears, two vascular ulcers, one blister, one skin cancer) and two pressure injuries (one stage-two and one suspected deep tissue pressure injury). Wound care specialist input was documented for all chronic wounds and pressure injuries.  Monitoring charts were in use; examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, restraint, food and fluid, turning charts, syringe driver monitoring, and behaviour monitoring as required. Not all monitoring forms evidenced that the required observations were being completed in the prescribed timeframes. |
| 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 team is led by an experienced activity coordinator. The team comprises a divisional therapist and seven other activities persons. All of the activity staff have completed Careerforce dementia education modules. The Bupa occupational therapist oversees the activity programme and meetings with the activity staff occur six weekly. The activity staff attend the Bupa education seminars for activity staff which occur twice a year.  There is a separate programme for the psychogeriatric and hospital level of care residents. Activities were evidenced occurring in each unit. Care staff were observed at various times throughout the day diverting residents from behaviours in the psychogeriatric units. There are 24-hour activity plans documented in the files reviewed for residents in the psychogeriatric units. There are resources available for care staff to use for one-on-one time with the resident. Staff could describe a low stimulus environment.  On or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six monthly and as part of the care plan review/evaluation a record is kept individual residents activities. There are recreational progress notes in the resident’s file that the activity officers complete for each resident every month. 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.  Families and residents interviewed reported satisfaction with the activities provided. Residents from all levels of care were observed to be participating in a wide range of activities. |
| 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. There is a comprehensive multidisciplinary review documented. The multidisciplinary review involves the RN, 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.  Written evaluations describe the resident’s progress against the resident’s 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. |
| 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 and RNs identified that the service has access to a wide range of support either through the GP, geriatrician, 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 are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, face shields and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available. |
| 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 certificate is posted at the entrance to the facility (expiry 1 January 2018).  Reactive maintenance and a 52 week planned maintenance schedule is in place that has been maintained. There is a full-time maintenance person employed who has completed health and safety training. The hot water temperatures are monitored weekly and maintained between 43-45 degrees Celsius. Where there was a variance in temperature outside of the target range in November 2016 corrective actions were evidenced to have been implemented and the issue resolved. There are contractors for essential service available who also provide an out of hours’ service.  The corridors are wide with handrails and 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 are well maintained. There is outdoor furniture and shaded areas. The three psychogeriatric units have a separate secure garden area providing shaded seating and walking areas. There is wheelchair access to all areas.  The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are shared ensuites in five of the six units. One psychogeriatric unit (Rata) has adequate numbers of communal toilets located near bedrooms. There are toilets adjacent to communal areas in all units. There is appropriate signage in the psychogeriatric units however, the hospital communal toilets and showers did not have signage. This was addressed at audit. The toilets, showers and ensuites have easy clean flooring and fixtures and handrails appropriately placed. Residents interviewed reported their privacy is maintained. |
| 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 | There are two shared rooms in Rata psychogeriatric unit; these currently have single occupancy. Both rooms include curtains for privacy and call bells. All other bedrooms in the hospital and psychogeriatric units are single rooms. They are spacious enough to manoeuvre transferring and mobility equipment to safely deliver 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 | There are lounges in each of the units. Each unit also has a kitchenette and open plan dining area. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this. Seating and space is arranged to allow both individual and group activities to occur.  There is adequate space in the psychogeriatric units to allow maximum freedom of movement while promoting safety for those that wander. There is an open plan dining/lounge area and smaller, quiet lounges available and seating alcoves. |
| 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 is done off-site at another Bupa facility. Dirty laundry is collected daily and clean laundry is returned daily for folding and dispersing. Laundry and cleaning audits are completed as part of the internal audit programme. The laundry and cleaning rooms are designated areas and clearly labelled. Chemicals are stored in locked rooms. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.  There are dedicated cleaning and laundry staff. Cleaning trolleys are well equipped and stored safely when not in use. Residents and relatives interviewed reported that they were satisfied 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 | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff with ongoing in-service training although attendance rates are low (link 1.2.7.5).  Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. Activities staff that go on outings with residents are also trained in first aid procedures.  There are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. Security systems are in place to ensure residents are safe. |
| 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 ceiling heating throughout the personal and communal areas. All communal rooms and bedrooms are well ventilated and light. Residents and family interviewed stated the temperature of the facility is comfortable. There is plenty of natural light in residents’ rooms. |
| 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 | Bupa has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. A registered nurse is the designated infection control officer with support from the clinical manager and other Bupa infection control officers. The IC team meets three monthly to review infection control matters. Minutes are available for staff in the staffroom. The clinical manager also sends a copy of the meeting minutes via email to each registered nurse. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. |
| 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 Parklands. The infection control (IC) officer who is newly appointed has completed the Ministry of Health online infection control education and is registered to attend an infection control seminar in March 2017. The infection control team is representative of the facility. External resources and support are available 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 facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control officer supported by the clinical manager who both completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided although staff attendance at these education sessions was noted to be low (link to 1.2.7.5). |
| 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 officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections are included on a monthly register and a monthly report is completed by the infection control officer. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly. Meeting minutes are made available to staff. Benchmarking occurs against other Bupa facilities.  Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Infection control data is collated monthly and discussed at the weekly RN meetings. The infection control programme is linked with the quality management programme.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and geriatrician that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. An outbreak in July 2016 was well managed and the required notifications made. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were twenty residents using restraint (eighteen psychogeriatric residents with t-belts and two hospital residents with either a table top or bedrails) and two residents using bedrails as enablers.  All necessary documentation has been completed in relation to the enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on RMSP/enablers has been provided, although staff attendance at restraint education is low (link 1.2.7.5). |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (unit coordinator/RN for the psychogeriatric units) and for staff are documented and understood, confirmed in interviews. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. Three files of psychogeriatric residents using restraint (t-belts) were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident’s restraint care plan although one care plan reviewed did not reflect the risks associated with the use the restraint (link 1.3.5.2). An internal restraint audit monitors staff compliance in following restraint procedures.  Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. T-belts are only put in place when necessary for the resident’s safety. Consistent evidence to verify two hourly checks was missing on the monitoring forms for three of six residents using t-belts as a restraint (sample size extended).  A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly, evidenced in three resident files where restraint was in use. The restraint coordinator reported that restraint use and the evaluation of each resident using restraint is also discussed in the RN meetings. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. Head office is in the process of preparing the 2016 annual review. The 2015 review of the restraint programme was sighted. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | A system is in place for education and training of staff that includes in-service training, competency assessments specific to worker type and impromptu toolbox talks that take place during handovers. In-service training attendance records reflect attendance rates at mandatory training frequently less than 50%. | i) Attendance at mandatory in-service training is below 50% (eg, code of rights, fire safety, accident and incident reporting, health and safety). The care home manager has identified this as an issue and plans to address it in 2017.  ii) Six of twelve staff files reviewed indicated that annual performance appraisals are behind schedule. The care home manager confirmed this finding and plans to address it in 2017. | (i) Ensure staff attend mandatory in-service training. (ii) Ensure staff appraisals are completed a minimum of annually.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Electronic medication charts reviewed corresponded with the signing administration records for regular and ‘as required’ medications. Warfarin administration was documented in the sample of two of three medication administration charts reviewed. On one paper medication chart reviewed, the dose of warfarin prescribed was not evidenced to be signed by a GP. | (i) On one paper medication chart for a hospital resident the dose of warfarin prescribed to be administered was not evidenced to be signed by a GP; and  (ii) Of a sample of three residents prescribed warfarin, one medication administration chart evidenced a gap of four days where the dose was not recorded as being administered as prescribed. | (i) Ensure prescribed medication is signed by the GP. (ii) Ensure that medication is documented as administered as prescribed.  30 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Twelve care plans were reviewed. All hospital and psychogeriatric resident files reviewed had in-depth care plans that included most of the assessed needs; however, three of the twelve care plans reviewed had not been updated to include changed resident needs. | (i) One hospital resident with a stage-three pressure injury (sacrum); the care plan had not been updated to reflect that the resident required two hourly changes of position. No turning chart was evidenced to be implemented;  (ii) One care plan (psychogeriatric) documented that the resident required the use of a restraint to manage the resident’s behavioural issue of wandering. The resident is now immobile. The care plan had not been updated to reflect that the use of restraint to manage this behavioural issue was no longer required; and  (iii)The care plan for one psychogeriatric resident had not been updated to reflect the risks associated with all methods of restraint in use. | Ensure care plans are updated as resident need changes.  60 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 RNs review information gathered from assessments, monitoring charts, observations, and interviews with residents, staff and families to develop the care plan. Interventions for assessed care needs were included in the care plan. Wound assessments and wound management plans were completed for all wounds. All complex wounds evidenced assessment and input from an external wound care nurse specialist. While monitoring forms were being utilised not all the required monitoring was fully documented. | a) The care plan for a psychogeriatric resident with a suspected deep tissue pressure injury documented two hourly turning (position changes were required). However monitoring forms reviewed did not evidence that position changes had been consistently completed in this timeframe.  b) One hospital resident (palliative care); the syringe driver monitoring form was not evidenced to be checked at a minimum of four hourly intervals as per policy. There was a large gap where checks were not documented as being completed between 6pm and 8am. | (a-b) Ensure that all monitoring forms document and reflect the frequency of monitoring prescribed.  60 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Low | Each episode of restraint use is only used intermittently for the resident’s safety. A method for monitoring while restraint is being used is established although is not always completed as prescribed. The restraint coordinator remarked that residents are regularly monitored but the care staff occasionally forget to complete the required paperwork. | Restraint monitoring forms were sighted for six residents using restraint (note the sample size was expanded). Three of the six monitoring forms for the months of January and February 2017 were incomplete. | Ensure monitoring forms reflect each episode of restraint as determined on the restraint assessment.  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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End of the report.