

Bupa Care Services NZ Limited - Fergusson Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Fergusson Rest Home & Hospital
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: 7 March 2017 End date: 8 March 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:	106

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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 Fergusson provides hospital (geriatric and medical), rest home and dementia level care for up to 112 residents. On the day of audit there were 106 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.

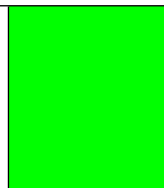
The care home manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse).

This certification audit identified that improvements are required in relation to the aspects of care planning, medication management and wound management.

The service has received a continued improvement rating around analysing quality data.

Consumer rights

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



Standards applicable to this service fully attained.

Bupa Fergusson 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

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.

Continuum of service delivery

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

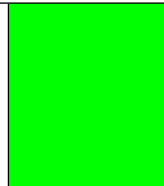
Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the 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 meets 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, secure 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 is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Hot water temperatures are monitored.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Bupa Fergusson has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. At the time of the audit, there were four residents with restraint and two residents with enablers. Restraint processes are being implemented.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	2	1	0	0
Criteria	1	97	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>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 (six caregivers, two RNs, two unit coordinators, one nurse educator/RN, one activity coordinator, one kitchen manager, the care home manager and clinical manager), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the residents' files reviewed. 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.</p> <p>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</p>

		provided. All resident files reviewed had a signed admission agreement.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	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. 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.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	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 Bupa Fergusson. Resident and relative meetings are held quarterly.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	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). Complaints received in 2016 and 2017 to date were reviewed. All were documented including investigation, follow-up letter and resolution. The number of complaints received each month is reported monthly to care services via the facility benchmarking spread sheet. 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 and at each nurses' station.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	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 unit coordinators discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Five residents (three rest home and two hospital) and eleven relatives (five rest home, four hospital and two dementia care) 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.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>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. One resident who identified as Māori was living at the facility. There are links to the local Orongomai marae. 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.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service 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. 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.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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 two relatives from the dementia unit</p>

		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.	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. A general practitioner (GP) visits the facility on a weekly basis and provides an after-hours service. The 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.</p> <p>The service receives support from the district health board, which includes nurse specialist's visits. Physiotherapy services are provided on-site eight hours per week. 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.</p> <p>Bupa has established benchmarking groups for rest home, hospital and dementia services. Bupa Fergusson 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.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>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. Fifteen 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.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay 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.</p>
Standard 1.2.1: Governance	FA	Bupa Fergusson provides hospital (geriatric and medical), rest home and dementia level care for up to

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>112 residents. On the day of audit there were 106 residents including one rest home resident receiving respite care and one hospital younger person's resident under 65 years of age (YPD). There were 51 of 53 residents in rest home beds, 38 of 41 hospital residents and 17 of 18 residents in the dementia care beds.</p> <p>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 Bupa Fergusson quality goals.</p> <p>The service has a goal in 2017 to decrease falls by 25% from 2016. Falls Management committee continue to meet monthly to discuss trends. There was a decrease in falls rate noted from October to December 2016 for rest home and hospital.</p> <p>Another goal they set is to decrease staff injuries as a result of resident behaviour by 50% from 2016 to 2017.</p> <p>The service is managed by a care home manager who is a registered nurse (RN). The care home manager has been in the role for one year and has been at Bupa for seven years. She is currently supported by an acting clinical manager (unit coordinator) and a new clinical manager/RN that has been in the role for one week. The new clinical manager has previous experience working as a clinical nurse manager overseas. The care home manager and clinical manager are supported by a Bupa regional manager and three unit coordinators. The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>During the temporary absence of the care home manager, the clinical manager or Bupa relieving facility manager covers the care home manager's role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>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</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>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.</p> <p>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.</p> <p>Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety committee. A health and safety officer (maintenance person) was 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.</p> <p>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 sensor 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. 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.</p>

an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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 RN staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction.</p> <p>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. Eighty-two per cent of the total staff have attained at least one Bupa Personal Best certificate. A total of 65% of caregivers have attained a Careerforce qualification.</p> <p>A total of 10 caregivers are employed to work in the dementia unit with nine having completed their national dementia qualification. The one caregiver is in process of completing their qualification and has been employed for less than six months.</p> <p>Registered nurses are supported to maintain their professional competency. Sixteen RNs and two enrolled nurses are employed. Ten of sixteen RNs have completed their InterRAI training. There are a number of implemented competencies for RNs including (but not limited to) medication competencies and wound care. Assistance with numeracy and literacy is available and is provided to those staff that request or need assistance.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a full-time care home manager who works from Monday to Friday. There are two unit coordinators (RNs) in the dementia and hospital units. An enrolled nurse is the unit coordinator in the rest home. The unit coordinators work from Monday to Friday.</p> <p>The clinical manager oversees the rest home and provides RN input in the rest home and supports the unit coordinators across all areas. There is also a RN in the hospital across all shifts. RNs are supported by sufficient numbers of caregivers across all shifts. 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 and staffing can be adjusted related to the needs of the residents. There is a pool of casual staff to cover leave and sickness.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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. Other residents or members of the public cannot view sensitive resident information. 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.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The admission policy and resident information handbook outlines access, assessment and the entry screening processes. The local community and needs assessment and coordination agencies are familiar with entry criteria and how to access the service. The service operates 24 hours a day, 7 days a week. Comprehensive information about the service is made available to referrers, potential residents and their families and sighted resident agreements contain all detail required under the Aged Residential Care Agreement. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>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. A transfer form accompanies residents to receiving facilities and communication with family is made. One file reviewed was of a resident that had been transferred to hospital acutely. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboards. Medication administration practice did not comply with the medication management policy for the medication round sighted. There was evidence of three monthly reviews by the GP. Registered nurses and caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. Not all medications were evidenced to be administered as prescribed. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication</p>

		fridges was not evidenced to be occurring as per Bupa policy. There were no residents self-administering medication on the day of audit. There are no standing orders.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a dedicated kitchen manager who oversees food management. The food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and there is a national menu in place that has been audited and approved by an external dietitian. There are policies in place to guide staff. All food is cooked on site in a large commercial kitchen. There is sufficient storage available. Stock rotation is practised. Hot food temperatures are monitored daily on all meals (records sighted). Fridges and freezers have temperatures monitored daily. Chilled inward goods are temperature checked on delivery and prior to storage. Daily air temperatures are recorded.</p> <p>Resident likes and dislikes are known, recorded in the kitchen and alternatives are offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes and is reviewed six monthly, as part of the care plan review. Special diets (ie, soft and pureed diets) are noted on the kitchen noticeboard, which can be viewed only by kitchen staff. Meals are served from bain-maries to the residents in the dining rooms and can be delivered to rooms as required. Specialist utensils and plates are available for residents.</p> <p>The resident annual satisfaction survey monitors food satisfaction. The kitchen is included in the internal audit programme. Staff have been trained in safe food handling and chemical safety.</p> <p>Residents and relatives interviewed commented positively on the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available or, if the person has health needs that are not able to be provided by the facility. If a potential admission was declined entry, the consumer and where appropriate their family/whānau of choice, is informed of the reason for the decline and provided with other options where they can access services.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a</p>	FA	<p>Bupa assessment booklets and care plans were comprehensively completed for all the permanent resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all permanent resident files. Files reviewed across the rest home, dementia and hospital units identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound</p>

timely manner.		care and restraint were appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Care plans reviewed were comprehensive, and demonstrate service integration and input from allied health. All resident care plans sampled were resident centred; however, not all support needs were documented in detail. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. One hospital resident had a specific 'End of Life' care plan in place following a change in health status. Other specific care plans were implemented for specific health needs, including (but not limited to) dementia, medical needs, diabetes, and chronic wounds. The contracted physiotherapist has completed transfer plans.</p> <p>Short-term care plans were in use for changes in health status 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 professionals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans were not fully completed for all wounds. On the day of audit, there were nineteen wounds. These included four chronic ulcers, five skin tears, one surgical skin graft, one cellulitis wound, two skin cancer lesions, one abrasion, one bruise, and four pressure injuries; (one stage-3, one stage-2 and two stage-1). Not all wounds have been reviewed in appropriate timeframes.</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, restraint monitoring forms, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p>
Standard 1.3.7: Planned Activities	FA	The activity team at Bupa Fergusson is comprised of one activity coordinator and three activity

<p>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.</p>		<p>assistants who deliver the activity programme over seven days per week.</p> <p>The two activity assistants who work in the dementia unit have completed NZQA level-4 dementia modules. The activity team have access to the Bupa diversional therapy (DT) team at head office and attend the regional DT/activities regional study days with training and education including guest speakers.</p> <p>Each resident has an individual activities programme, which is reviewed when their plan of care is reviewed and as part of their InterRAI assessments.</p> <p>The group activity programme is implemented over seven days per week in all three areas. There is an extremely large open plan central lounge/dining area which is used for activities for rest home and hospital residents. There are ranges of activities offered. There are separate rest home/hospital and dementia programmes with activities that meet the needs and preferences of the resident groups; however, some activities are integrated such as entertainment, as observed on the day of audit. Variations to the group programme are made known to the residents. Residents may choose to participate in any group programme. Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme.</p> <p>The group programme covers physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community groups. Targeted group programmes are offered as appropriate to meet the needs of subsets of residents. There is a weekly Catholic church service and some residents attend church services in the community. Residents can go on outings using the service's van. Some rest home residents choose to use alternative transport arrangements to attend community interests. A caregiver accompanies the activity person on outings. There is a designated van driver.</p> <p>Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting and resident satisfaction surveys.</p> <p>Residents and relatives interviewed were satisfied with the activities programmes on offer.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses six monthly, or when changes to care occurs. Written evaluations reviewed described the resident's progress against the residents identified goals. Short-term care plans for short-term needs are evaluated and either resolved or added to the long-term care plan as an ongoing need. The six-monthly multidisciplinary review involves the RN, GP, activities staff, physiotherapist (if involved) and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. 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.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is 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 registered nurses identified that the service has access to a wide range of support either through the GP, Bupa specialists or contracted allied services. YPD residents are assisted to access community groups and health services as needed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There is an effective system of waste management in place. Chemicals are supplied by an external contractor and stored securely throughout the facility when not in use. Appropriate policies are available along with chemical product safety charts. Education on hazardous substances occurs at orientation and is included in in-service training. There is appropriate signage throughout regarding chemical storage and hazards. There is personal protective equipment available for use by staff and this was in use on the day of audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness, which expires 16 November 2017. The facility employs a full-time maintenance manager. There are proactive and reactive maintenance management plans in place. The grounds and gardens are maintained by a qualified gardener who assists with maintenance. Contracted providers test equipment. Electrical testing of non-hard wired equipment was last conducted on 11 March 2016. Medical equipment requiring servicing and calibration was last conducted on 6 July 2016. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	FA	<p>There are adequate toilets and showers for residents. Some rooms have a shared ensuite. Separate visitor and staff toilet facilities are available. Water temperatures are monitored and temperatures are maintained at or below 45 degrees Celsius. Fixtures fittings and flooring are appropriate and</p>

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.		toilet/shower facilities are constructed for ease of cleaning.
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	Resident rooms are spacious. Walking frames, wheelchairs and hoists can be manoeuvred around the bed within the rooms, if required. Residents requiring transportation between rooms or services can be moved from their room either by trolley or by wheelchair.
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 several lounges throughout the facility and combined lounge/dining rooms. Residents can move freely. Activities occur mainly in the large rest home/hospital combined living/dining area. There are quiet areas if people wish to speak privately. Activities in the dementia unit occur in the lounge. There are safe and secure garden areas in the dementia unit with seating and shade provided, creating a "loop" walkway for residents.
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	A team of household staff managed by the full-time household supervisor cleans the facility. The household staff have access to the appropriate equipment and chemicals. Cleaning equipment and cleaning chemicals are stored securely when not in use. Laundry services are completed on site. Internal audits are completed to monitor performance. Household staff receive training at orientation and through the in-service programme. There are policies in place to guide practice.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an	FA	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. The facility has an annual emergency procedure inspection training around the site. 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. The last fire evacuation drill occurred on 28 February 2017. Smoke alarms, sprinkler system

<p>appropriate and timely response during emergency and security situations.</p>		<p>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 (generator) 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.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is light and airy and able to be ventilated by opening external windows and doors. There is overhead electric heating with some heat pumps located in public areas. Internal temperatures are monitored and regulated by the maintenance manager.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>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 infection control officer is a registered nurse (CM) and she 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. A lower north/southern regional infection control meeting addresses infection control issues across the organisation. The infection control programme is well established at Bupa Fergusson. The quality/infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, and local community laboratory. In October 2016, a gastro outbreak and in January/February 2017 a suspected respiratory outbreak, was evidenced to be well managed with the relevant authorities having been notified.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Bupa Fergusson. The infection control (IC) officer has maintained best practice by attending infection control updates. 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.</p>

<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Infection control training was last provided October 2016.</p> <p>The infection control officer has received education by an external provider to enhance her skills and knowledge. The infection control officer has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.</p> <p>A number of toolbox talks have been provided, including (but not limited to) preventing UTIs and the importance of hand hygiene.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p>

		<p>Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark.</p> <p>All infections are documented monthly in an infection control register.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Currently the service has four residents on five restraints (one bedrail and four lap belts) and three residents with enablers (two bedrails and one lap belt). Residents using enablers have voluntarily signed a consent form.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The nurse educator/RN is the restraint coordinator for the facility and has defined responsibilities included the job description. Bupa has a regional restraint group at an organisation level that reviews restraint practices. Teleconferences are arranged twice a year and include the restraint coordinators at each of the Bupa facilities. Only staff that have completed a restraint competency assessment are permitted to apply restraints. Restraint competencies are completed annually and there is ongoing education including restraint minimisation and challenging behaviours. Quality and clinical meetings include discussion on restraint.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments are undertaken by the RNs in partnership with the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Ongoing consultation with the resident and family/whānau was also identified. A restraint assessment form was completed for the four residents requiring restraint (sighted). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes</p>

Services use restraint safely		ensuring the environment is appropriate and safe. Restraint authorisation is in consultation with the consumer (as appropriate) or family/whānau and the facility restraint coordinator. Overall, each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Everyone has their own register of restraint or enabler use which provides an auditable record. Restraint use is used as a last resort in keeping with the Bupa restraint minimisation policy.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation considers the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment for residents on the restraint register, and as part of their care plan review. Families are included as part of this review where possible.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. Reduction of restraint is an ongoing target at the facility as they constantly work on the reduction of restraint within the facility every year. The organisation and facility are proactive in minimising restraint. Restraint education and training programme is in place, which includes restraint competencies.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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,</p>	<p>PA</p> <p>Moderate</p>	<p>The services medication management policy outlines the policies and practices to be followed in relation to medication management. Staff interviewed who administer medication, could describe safe medication management and administration practices. Medication rounds observed in the hospital and dementia units were completed as per policy and procedure. However, this was not observed during the lunchtime medication round in the rest home. The medication fridge temperatures are required to be checked and recoded daily. This was evidenced to be completed in the hospital and dementia unit. However, medication fridge temperatures had not been consistently recorded in the rest home. Medication was not evidenced to have been given as prescribed for one resident.</p>	<p>(i) Medication was not evidenced to be administered as prescribed. A gap of six days was evident in one medication chart where the prescribed dose of anticoagulant was not evidenced to have been administered. (ii) Temperature recordings for the medication fridge in rest home were not evidenced to be recorded daily. (iii) A medication trolley was observed left unattended and unlocked in the rest home dining area.</p>	<p>(i) Ensure medication is documented as administered as prescribed. (ii) Ensure fridge temperature monitoring is conducted as per policy. (iii) Ensure medication trolleys are not left unlocked</p>

protocols, and guidelines.				or unattended. 30 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Care plans were developed by the registered nurse and were based on information gathered through the assessment process. Nine of eleven care plans documented all the support needs in detail. However, one rest home resident did not have the management of complex partial seizures documented in the care plan. A management care plan was documented on the day of audit.</p> <p>Care plans were documented for the use of a restraint or an enabler, which included the risk factors associated with the use of the restraint or enabler and the required frequency of monitoring when in use. However, one hospital resident did not have a care plan documented for the use of an enabler.</p>	<p>i) One hospital resident did not have the use of an enabler (bed rail) documented in the care plan; and</p> <p>ii) One rest home resident did not have a care plan documented for the management of complex partial seizures.</p>	<p>i-ii) Ensure care plans are documented for all assessed care needs.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Wound assessment, monitoring and wound management plans are in place for all wounds, however not all wound care documentation was fully completed or updated.</p>	<p>(i) Three of eight rest home and two of nine hospital wound assessment and treatment plans did not evidence that the wounds had been reviewed in the prescribed timeframe; and (ii) In the rest home, one of eight initial wound assessments did not document the classification (stage) of pressure injury and two of eight wound assessments did not document the classification of skin tear as per Bupa Policy.</p>	<p>(i) Ensure wounds are reviewed within the prescribed timeframe; and (ii) Ensure the classification of wounds is documented on wound assessment forms as per Bupa Policy.</p> <p>90 days</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>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.</p> <p>Audit summaries and action plans are completed as required, depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff), and an action</p>	<p>Fergusson is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data collected, the clinical manager feeds back monthly to staff at handover and staff meetings arising and identified trends or issues. A number of corrective actions were sighted around clinical actions being above the benchmark across all three areas. For example, the service developed a QI-CAP (quality indicator- corrective action plan) when pressure injuries were above the benchmark in June 2016 in the hospital. Strategies (including care strategies) were reviewed for individual residents, amended as needed and evaluated for effectiveness. There is a RN appointed as wound nurse liaison for the facility. The wound nurse liaises with the manager to ensure adequate supply of wound dressing products and provides best practice initial advice on wound management and provides education to staff on wound management. There is also a HVH DHB wound specialist available for advice & support for any wound management issues. The service had no further PIs in July and ongoing strategies reviewed in August. Any identified common themes around incidents/infections etc. results in further education, toolbox sessions and meetings.</p>

		<p>plan is identified. These were comprehensively addressed in meeting minutes sited.</p> <p>Benchmarking reports are generated throughout the year to review performance over a 12-month period. The service continues to collect data to support the implementation of corrective action plans. A number of corrective actions were sighted around clinical actions being above the benchmark across all three areas. Corrective actions were evaluated for effectiveness. Responsibilities for corrective actions are identified.</p> <p>Fergusson is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified</p>	
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End of the report.