# Bupa Care Services NZ Limited - Rossendale Dementia Care Home & Hospital

## Introduction

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

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

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

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

The specifics of this audit included:

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

**Premises audited:** Rossendale Dementia Care Home & Hospital

**Services audited:** Hospital services - Psychogeriatric services; Dementia care

**Dates of audit:** Start date: 13 March 2017 End date: 13 March 2017

**Proposed changes to current services (if any):** The service reconfigured their beds in May 2016 by increasing the hospital psychogeriatric unit by six beds and decreasing the dementia units by six beds. The total number of beds will remain at 100 made up of 89 psychogeriatric beds and 11 dementia beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 97

# 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** |
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|  | 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

Rossendale Home and Hospital is part of the Bupa group. The service provides psychogeriatric level care and dementia level care for up to 100 residents. On the day of the audit there were 89 residents across the psychogeriatric units and 11 residents in the dementia unit.

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

Rossendale is managed by a registered nurse who has been in the position for eight years. She is supported by a clinical manager and Bupa regional manager. The relatives interviewed spoke positively about the care and support provided.

The service has continued to maintain a comprehensive quality and risk management process. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. This audit has identified no areas requiring improvement.

The service is commended for maintaining continued improvement ratings around quality goals and implementation of the quality system.

## 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. |

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter’s policy is in place. Family members and staff, from a range of cultures, are the most common source of interpreter services within the facility. External assistance is available if necessary. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaint register that is up-to-date and includes relevant information regarding the complaint. Documentation including follow-up letters and resolution demonstrates that complaints are well managed.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | All standards applicable to this service fully attained with some standards exceeded. |

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. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Rossendale is benchmarked in two of these (psychogeriatric and dementia). 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. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Registered nursing cover is provided 24 hours a day, 7 days a week.

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

A comprehensive information booklet is available for residents/families at entry, which includes information on the service philosophy, services provided and practices to the secure units. The care home manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed were based on the InterRAI outcomes and other assessments. They were clearly written and caregivers report they are easy to follow. Families interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community nurse as required.

There is a group activity programme developed for each unit. Individual activity plans have also been developed in consultation with resident/family. The activity programme includes meaningful activities that meet the recreational needs and preferences of the psychogeriatric and dementia residents.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners or the nurse practitioner review residents at least three monthly or more frequently if needed. There are regular visits and support is provided by the community mental health team and psychogeriatrician.

All meals are prepared on site. Resident’s individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period in all areas.

## Safe and appropriate environment

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

A current building warrant of fitness is posted in a visible location (1 December 2017).

## Restraint minimisation and safe practice

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

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service has one resident using an enabler with 30 residents assessed as requiring the use of restraint.

## 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 surveillance programme is appropriate for the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 1 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 43 | 0 | 0 | 0 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Complaints received are managed by the care home manager. At the time of the audit there had been seven complaints made across 2016 and two received in 2017 year to date. There was a complaint management record completed for each complaint. All complaints had been investigated with appropriate documentation on record. A record of complaints each month is maintained by the care home manager on the complaint register. The number of complaints received each month is included in the Bupa benchmarking programme. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. Interview with relatives confirm they were provided with information on complaints and that a complaints procedure is provided to residents within the information pack at entry. The service is proactive in implementing actions following complaints, with examples including improvement to restraint monitoring. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy that guides staff in their responsibility to notify family of any accident/incident that occurs. Accident/incident forms include a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms were reviewed from March 2017 across the service. Family had been notified appropriately in all instances. There is an interpreter policy and staff are aware of how to access interpreters if required. There are a number of residents (and staff) from a variety of cultures and family interviewed were particularly complimentary of how staff are able to communicate with residents where English is a second language. The eight relatives interviewed stated that they are informed when their family members health status changes. Family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | Bupa Rossendale provides psychogeriatric (PG) dementia level care for up to 100 residents. There were 98 residents at the time of audit including, 11 residents in the 11-bed dementia unit and 87 residents across the 89 PG level beds (under the Hospital Specialist Services ARHSS contract). The 87 residents at PG level care included 10 residents in the 10-bed high dependency unit, 27 residents in a 29-bed psychogeriatric unit, and 50 residents in the other 50-bed psychogeriatric unit (referred to by the service as the hospital). As per HealthCERT letter dated 27 April 2016, this audit also included verifying reconfigured beds. The service moved a secure door which resulted in an increase of hospital beds in the psychogeriatric unit by six beds and decreasing the dementia unit by six beds. The total number of beds remain at 100 made up of 89 psychogeriatric beds and 11 dementia beds. Bupa has a quality and risk framework that is being implemented at Rossendale.  There is an overarching business plan and risk management plan for the organisation.  Each facility then develops quality goals for the year.  Rossendale goals for 2017 include reducing falls, pressure areas, skin tears and resident behaviours. Rossendale continues to develop annual quality goals. As part of the process they develop strategies, evaluate their effectiveness, and update them as needed as they evaluate the outcome.Progress towards these goals is minuted in the various meetings held at the service.  Rossendale’s care home manager is a registered nurse who has been in post since 2009.  She is supported by a clinical manager who has been in the role for three years.  The care home manager is supported by a regional manager who in turn is supported by the organisations clinical and management infrastructure.  This infrastructure includes regular meetings, six monthly forums and a national conference which managers attend. The care home manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a hospital. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Bupa has a comprehensive quality and risk management system that is being implemented at Rossendale. The quality programme includes monthly benchmarking by service type. Rossendale benchmarks against dementia and psychogeriatric level care. Benchmarking is also undertaken in respect of infection rates and restraint usage. Rossendale is unique in that they are a large psychogeriatric service and benchmarking ‘like against like’ is therefore challenging. Benchmarking data is discussed at the monthly quality meetings and then at the various staff meetings. This data is also aggregated at an organisational level and reported monthly. Data is graphed and available in the staff room. Outstanding matters are seen to have been followed through to the next meeting. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The Bupa policy review committee develops organisational policies appropriate for aged residential care services that align to current accepted practice. Policies are reviewed regularly and facilities are encouraged to have input into their review. There is a document control process being implemented that ensures the most current document is in use in clinical areas. Bupa prescribe an annual internal audit programme that is being implemented at Rossendale. Corrective action plans are developed and seen to be closed out at the time of audit. Rossendale also develops corrective action plans where monthly benchmarking outcomes rate above the accepted threshold. Staff are informed of audit outcomes and involved in corrective action plans. Annual relative surveys are undertaken and there has been an increase in overall satisfaction with the service from 89% in 2015 to 92% in 2016.Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety committee. The health and safety committee collates and discusses staff incidents/accidents. 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 (B-fit) is in place, which is linked to the overarching Bupa National Health and Safety Plan.  |
| 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 | The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Individual incident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Twelve incident forms were reviewed across the service and all demonstrated clinical follow-up by a registered nurse/unit coordinator and monitoring (such as neurological observation forms) having been undertaken when indicated. Relatives were reported as having been informed as appropriate in all reviewed. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files (one clinical manager, two RNs, two caregivers, one diversional therapist and one household manager) were reviewed and all had personal file checklists. Performance appraisals were current in all files reviewed. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type and includes documented competencies. New staff are buddied for a period of time. Staff interviewed stated that they believed new staff were adequately orientated to the service. As part of their orientation caregivers complete a booklet that has been aligned with foundation skills unit standards, effectively attaining their first national certificates. There is an annual education schedule that is being implemented and an RN/EN training day provided through Bupa that covers clinical aspects of care. External education is supported a Rossendale. A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained. Staff interviewed are aware of the requirement to complete competency training. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. There is a staff member with a current first aid certificate on every shift. There is a total of 62 caregivers and of these 55 have completed the dementia standards. The other seven staff have commenced the standards and these staff have been at the facility for less than 12 months. Rossendale has a high uptake of the personal best programme run through Bupa with 97% of total staff having attained at least one Bupa Personal Best certificate. A total of 92.5% of caregivers have attained a Careerforce qualification with the remaining 7.5% of staff are currently enrolled on Careerforce education programmes. This work has had a positive impact on reported satisfaction from relatives, where the overall satisfaction increased from 89% in 2015 to 92% 2016. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. Registered nurse cover is provided 24 hours a day, 7 days a week. There is at least one RN and first aid trained member of staff on every shift. The three PG units have a RN rostered on the morning shift (including two RNs in the 50-bed PG unit). There is an EN (or RN) rostered in the dementia unit AM and PM shift. There are three RNs on night shift across the PG units. Registered nurses are supported by sufficient numbers of caregivers across each shift and area. Interview with caregivers informed that RNs and management are supportive and approachable. Separate laundry and cleaning staff are employed seven days a week. Interviews with staff, residents and relatives informed there are sufficient staff to meet the care needs of the residents. With the reconfiguration of PG and dementia beds in 2016, the roster was amended at the time to reflect change in needs.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Twelve medication charts were reviewed (eight psychogeriatric and four dementia level). There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication system and all medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medicine administration. Standing orders are not in use. There are no residents self-medicating at Rossendale. The GP reviews the use of antipsychotic medication and if required makes a referral to the psychogeriatrician. The medication fridge temperatures are recorded regularly and these are within acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Bupa Rossendale are prepared and cooked on site. Bupa policies and procedures are available. The national menus have been audited and approved by an external dietitian. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met. Meals are plated and then transported from the kitchen to the residents in each unit in hot boxes. Meals are served directly from the main kitchen to the dining area for residents in the larger psychogeriatric unit. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. There is evidence that additional nutritious snacks are available over the 24-hour period.Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed or are currently completing their food safety course. There is specialised crockery such as lip plates and mugs and utensils to promote resident independence with meals. Families can provide feedback on the menu and food services through the family meetings and resident/family surveys.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans are completed by the registered nurses. When a resident’s condition alters, the registered nurse initiates a review and if required, GP or nurse practitioner consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medication. Discussions with families are documented on the family contact form in the resident file. In the residents’ files reviewed, short-term care plans were commenced with a change in heath condition and linked to the long-term care plan. Long-term care plans were reviewed at least six monthly. Challenging behaviour assessments are well documented with amendments made to the care plan as required. There is regular input into the residents’ care from the visiting community mental health specialist nurses and the psychogeriatrician. There is evidence in the medical notes of GP communication with the psychogeriatrician regarding medication review.Continence products are available and resident files include a urinary continence assessment, bowel management, and the continence products required are identified. Adequate dressing supplies are available. Wound management policies and procedures are in place and weighs are recorded at least monthly.The clinical manager and registered nurses (interviewed) described the referral process should they require assistance from a wound specialist, continence nurse, dietitian, speech language therapist, diabetes nurse or other allied health or nursing specialists. There are several monitoring forms available for use that include two hourly turns, blood pressure, weight, fluid balance charts, food monitoring, behaviour, blood sugar monitoring, bowel records, continence diary, restraint monitoring and neurological observations.The care team and diversional therapists interviewed could describe strategies for the provision of a low stimulus environment.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | A team of three diversional therapists and three activities coordinators provide an activities programme in each of the units. Care staff and the activities staff working in the high dependency unit could describe how they create and promote a low stimulus environment (observed). The activities programme is developed to cover seven days a week in the hospital and Monday to Friday in all other units. Care staff on duty are also involved in individual activities with the residents as observed on the day of audit. Participation is voluntary and one-on-one activity time is provided for residents who choose not to participate in activities. The programme observed was appropriate for older people with mental health conditions and dementia. The programme is developed monthly and displayed in large print on noticeboards; a weekly plan is also displayed. There are resources available to staff for activities. Entertainment is scheduled fortnightly in each unit. There is a van outing weekly for residents. The activities staff have a current first aid certificate. The service has access to a wheelchair van. 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 as part of the care plan review/evaluation. A 24-hour recreational plan was evidenced in the files reviewed. A record is kept of individual resident’s activities. Each resident has a 'map of life'. The resident/family/whānau as appropriate is involved in the development of the activity plan. Family are invited to attend the resident meetings chaired by the manager. This meeting provides an opportunity for feedback and suggestions regarding the programme, outings and entertainment. Relatives interviewed are happy with the choice and variety activities offered.Caregivers were observed at various times throughout the audit diverting residents from behaviours. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the residents’ files reviewed all initial care plans were documented and evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes. The multidisciplinary review involves the RN, GP, nurse practitioner, activities staff and 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. The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were seen in all residents’ files sampled. On-going nursing evaluations occur daily/as indicated and are documented within the progress notes.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 1 December 2017).As per HealthCERT letter dated 27 April 2016, this audit also included verifying reconfigured beds. The service moved a secure door which resulted in an increase of hospital beds in the psychogeriatric unit by six beds and decreasing the dementia unit by six beds. The total number of beds remain at 100 made up of 89 psychogeriatric beds and 11 dementia beds. The secure door is connected to the fire system. The six resident rooms are large enough for mobility equipment and staff. There are communal bathrooms within close proximity. The communal lounge/dining area allows for an increase in resident numbers. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate training, information, and equipment for responding to emergencies is provided. Fire evacuations are held six monthly and the last drill was 5 December 2014. There is staff across 24/7 with a current first aid certificate. There is a comprehensive civil defence manual and emergency procedures manual in place. The call bell system is available in all areas with indicator panels in each area. As per HealthCERT letter dated 27 April 2016, this audit also included verifying reconfigured beds. The service moved a secure door which resulted in an increase of hospital beds in the psychogeriatric unit by six beds and decreasing the dementia unit by six beds.The fire service stated that the door that was relocated is compliant and drops on fire. There was no need to change the evacuation scheme as the doors only moved down the corridor a few meters. These doors were checked last month with the trial evacuation test and functioned correctly also. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is restraint minimisation and safe practice policies applicable to the service. Guidelines around the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. There are currently 32 residents in the psychogeriatric unit using restraint bedrails and lap belts and one resident with an enabler (lap belt). Documentation was reviewed for seven restraints and one enabler and evidences assessment, authorisation, consent, planning, monitoring and review of the devices has been completed, and complies with the organisational policy. Staff regularly receive training in the management of challenging behaviour and de-escalation strategies.  |

# 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.

|  |
| --- |
| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.1.1The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | There is an overall Bupa business plan and risk management plan. Rossendale has set specific quality goals for 2017. The service has been proactive in following through goals each year with quarterly progress and evaluations.Rossendale annual goals also link to the organisations goals and this is reviewed in quality meetings and in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Rossendale continues to implement Bupa’s ‘personal best’ initiative whereby staff are encouraged to enhance the lives of residents. Regular ‘tool box’ talks are held with staffThe Bupa CNS provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia, (e.g., mortality and pressure incidence rates and staff accident and injury rates). There is benchmarking of some key indicators with another NZ provider. The facility manager provides a documented weekly report to the Bupa operations manager. The operations manager visits regularly and completes a report to the general manager Care Homes.  | Rossendale continues to develop annual quality goals. As part of the process they develop strategies, evaluate their effectiveness, and update them as needed as they evaluate the outcome. The service implements two organisational goals and three site-specific goals. Two goals link to the organisations B-fit goal and one national H&S goal. The service has embedded the B-fit calendar and actions to initiate this. On-going evaluation monthly and feedback from staff identifies improvement to physical health and teamwork. Goal 2 - to further reduce staff incidents caused by residents. Strategies included (but not limited to) on-going behaviour management training and identifying champion caregivers for each area to assist staff around de-escalation training/management. Strategies were evaluated quarterly and while incidents were minimised, their goal was not met for 2016 and further actions have been identified for 2017. Site-specific goals included; (i) and (ii) to reduce pressure injuries by 5% and skin tears by 3%. Strategies were implemented throughout the year, evaluated quarterly and identified improvement in 2015. (iii) To reduce bruising by 3%; a number of strategies were implemented throughout the year. The restraint and falls focus group included input into strategies. Outcomes were evaluated quarterly and further strategies were implemented. This goal has been carried over to 2017 as it wasn’t achieved in 2016.  |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The service has continued to maintain a comprehensive quality and risk management process. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required, depending on the result of the audit. Key issues are reported to the appropriate committee (e.g., quality, staff) and an action plan is identified. These were comprehensively addressed in meeting minutes sited.Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Rossendale and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Rossendale is proactive in developing and implementing quality initiatives. | Rossendale is active in analysing data collected monthly, including (but not limited to) 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 identified trends or issues. Any identified common themes around incidents/infections etc. results in further education, toolbox sessions and meetings. Quality indicator corrective action plans are implemented where the service is above the benchmark, for example, bruising was above the benchmark across the psychogeriatric units May – July 2016, and skin tears were above the benchmark in the dementia unit May – July 2016. As a result of the on-going strategies to minimise, increased education and on-going monitoring of the strategies, evaluation identified that incidents dropped below the benchmark from August 2016. |

End of the report.