# Bupa Care Services NZ Limited - Sunset 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](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:** Sunset Rest Home & Hospital

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

**Dates of audit:** Start date: 29 August 2017 End date: 30 August 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:** 123

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Bupa Sunset Rest Home and Hospital is certified to provide rest home, hospital, dementia and residential disability levels of care for up to 124 residents. Over the course of this audit, there were 123 residents.

This certification audit was conducted against 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, interviews with residents, family, management, staff, a general practitioner and a nurse practitioner.

The care home manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse). There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There are four areas of continuous improvement awarded around good practice, quality indicator data results, food and nutrition, and infection control.

## Consumer rights

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

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

## Organisational management

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

The care home manager is supported by a clinical manager, registered nurses, caregivers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held and satisfaction is monitored via annual satisfaction surveys. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. A comprehensive education and training programme is implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is a comprehensive admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines and complete education and medication competencies. Medication charts are reviewed three-monthly by the GP.

A kitchen manager oversees food provision. All meals and baking are prepared on-site. The menu plans have been reviewed by a dietitian and are suitable for the elderly and/or disabled residents. The menus are clearly documented and displayed daily. The individual dietary needs are identified during the assessment process for each resident and choices are provided. Meals are provided at appropriate times of the day.

An activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are planned that are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Community outings are arranged and entertainers are invited to participate in the programme. Special consideration is given to younger people when planning the activities programme.

## Safe and appropriate environment

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

The existing building holds a current warrant of fitness and an approved fire evacuation plan. The facility is well-maintained. There are effective waste management systems in place and chemicals are stored safely. Hazardous risks are identified and managed. All cleaning supplies are stored in locked cupboards.

Security cameras are strategically located inside and outside of the facility. All windows have security locks that are checked each night by staff. A security company patrols in the hours of darkness.

Residents’ rooms are single accommodation. Resident rooms are personalised with residents bringing their own personal belongings. There is a large lounge and dining area in each wing. There is adequate space for residents to move freely. Exterior areas are well-maintained with a secure garden area located in the dementia unit.

In the event of a disaster or a pandemic, emergency plans are in place with civil defence kits strategically placed throughout the facility and spills kits readily available. Fire drills take place every six months. Emergency water and food supplies are sufficient for a minimum of five days for residents and staff. There is a generator and gas barbeques on-site. A minimum of one staff is always available with a current first aid and CPR certificate. A registered nurse is always on-site.

## 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. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were eleven residents using restraint and two residents with an enabler. Restraint management processes are adhered to.

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

Bupa Sunset has an infection control programme that complies with current best practice. There is a dedicated infection control nurse who has a role description. The infection control programme is reviewed annually at organisational level. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Records of all infections are now kept electronically for benchmarking.

## 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** | 3 | 47 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 97 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with the care home manager, clinical manager/RN, and fourteen staff (five caregivers, three registered nurses (RNs), two activities staff, one cleaning supervisor, one kitchen manager, one laundry manager, one maintenance staff) confirmed their familiarity with the Code and could provide examples of how they apply this knowledge to their working environment. Interviews with twelve residents (seven rest home which included one resident on the young person with a disability (YPD) contract, and five hospital) and eight relatives (three hospital, two rest home, three dementia) confirmed that the services being provided are in line with the Code. The Code is discussed at the residents’ meetings and staff meetings. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has a policy for informed consent. Completed resuscitation consent forms were evident in all 12 resident files reviewed (four hospital - including one long-term chronic conditions (LTSCC) contract, four rest home including one YPD contract and four dementia). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence was filed in the residents’ charts. Interviews with residents and relatives confirmed discussions around gaining consent. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is a policy that describes the role of advocacy services. Staff receive annual training on advocacy. Information about accessing advocacy services is available in the information presented to residents and their families during entry to the service. Advocacy support is available if requested. Interviews with staff, residents and relatives confirmed that they were aware of advocacy services and how to access an advocate. An appointed advocate and their contact details are posted in a visible location for residents and families to access.  The complaints process reminds the complainant of their right to contact the health and disability advocacy service with contact details provided. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain family and friends’ networks. Care staff interviewed confirmed that residents are encouraged to build and maintain relationships. Visiting can occur at any time. Community links were evident. Community links are through the local churches, the RSA and residents going out on regular outings. Special outings are in place for the four residents on the YPD contract (two rest home and two hospital) and include one-on-one shopping visits, and taking them out to lunch. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint’s register. Two complaints have been lodged in 2017 (year-to-date). Verbal and written complaints are documented. Both complaints had a noted investigation. Timelines determined by HDC were met, and corrective actions were implemented. One of the complaints lodged around residents’ cares involved the DHB. The action plan was developed with assistance provided by the DHB portfolio manager (28 April 2017) and was signed off on 6 June 2017. Examples were provided during the audit to ensure that corrective actions were continuing to be implemented.  Complaints are linked to the quality and risk management system. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters displaying the Code in English and in Māori. The service is able to provide information in different languages and/or in large print if requested. On entry to the service the care home manager or clinical manager discusses the Code with the resident and the family/whānau. Information is given in the information pack to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. During the audit, staff were observed gaining permission prior to entering residents’ rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents’ cares. Residents and family members interviewed confirmed that staff promote the residents’ independence wherever possible and that residents’ choices are encouraged. There is an abuse and neglect policy that is implemented and staff have undertaken annual training on abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has established Māori cultural policies to help meet the cultural needs of its Māori residents. Bupa has developed Māori tikanga best practice guidelines, which are posted in visible locations. The service has established links with local Māori advisors including the Waipareira Trust. Staff training includes cultural safety training. A cultural assessment is completed during the Māori resident’s entry to the service. There was one hospital level resident who identified as Māori but was unable to be interviewed. Whānau were also not available. The residents’ file identified specific cultural preferences (eg, listening to Māori radio and television, not to touch the head without consent). |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents’ cultural and individual values were being met. Information gathered during assessment including residents’ cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. There were eight (Indian) residents at the facility who were unable to speak English proficiently. The multicultural staff and families are able to assist with translation. Indian food is cooked for the Indian residents daily. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with all staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (eg, wound care, mental health) and staff education and training. Physiotherapy services are provided nine hours per week. There is a robust education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain independent. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of family communication is held in the front of each resident’s file.  Twenty incidents/accidents forms selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member’s health status.  Interpreter services are available if needed. Staff and family are utilised in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa Sunset Care Home is part of the Bupa group of aged care facilities. The care facility has a total of 124 beds suitable for rest home, hospital (geriatric and medical) and dementia levels of care. The facility is also certified for residential disability (physical and intellectual). During the audit, there were 123 residents (32 rest home, 64 hospital, and 27 dementia). There are 49 dual-purpose beds located on the ground and second levels. The first level of the facility is hospital level only. Four residents (two rest home and two hospital) were on the young persons with a disability (YPD) contract and three residents (one hospital, two rest home) were on the LTSCC contract.  Bupa's overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is an overall Bupa business plan and risk management plan. There are documented quality/health and safety goals that are reviewed monthly and signed off when achieved.  The care home manager has worked in aged care and management for over nine years. She is supported by an experienced clinical manager/RN. Both the care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the care home manager, the clinical manager/RN is in charge. In the absence of the clinical manager/RN, a unit coordinator/RN is in charge of clinical operations. For extended absences, a Bupa relieving care home manager is rostered. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.  Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed with results communicated to staff. Data collected is benchmarked against other Bupa facilities. Corrective actions are implemented where benchmarked data exceeds targets. Corrective actions around falls and managing challenging behaviours have had positive results.  An internal audit programme is in place. In addition to scheduled monthly internal audits, an annual facility health check is conducted by an external Bupa representative. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented. Corrective actions from the last health check (22 June 2017) identified corrective actions that have been implemented and signed off. Quality and risk data is shared with staff via meetings and posting results in the staff room.  The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is an appointed health and safety officer who is supported by health and safety representatives. The health and safety team meets three-monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed three-monthly. Bupa belongs to the ACC partnership programme and has attained their tertiary level (expiry 31 March 2018).  Strategies are implemented to reduce the number of falls. This includes, but is not limited to ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all 20 accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations.  The facility is moving towards the use of an electronic database (Riskman) for adverse event reporting purposes. Hardcopy accident/incident forms were reviewed during this audit.  Discussion with the care home manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. A register of current practising certificates is maintained. Ten staff files reviewed (five caregivers, one activities coordinator, one kitchen manager and three RNs) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions.  The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. The education programme being implemented is extensive and includes in-service training, competency assessments, and impromptu (tool box) talks. Caregivers are expected to complete an aged care education programme that meets the New Zealand Quality Authority (NZQSA) requirements.  The kitchen manager has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on-site. Chemical safety training is included in staff orientation and as a regular in-service topic.  Six of eleven RNs and two ENs have submitted their PDRP. Eleven of twelve RNs have completed their interRAI training. The care home manager, clinical manager and staff attend external training including sessions provided by the district health board.  Sixteen caregivers work in the dementia unit. Thirteen have completed their dementia qualification and the remaining three caregivers are enrolled and have been working in the unit for less than one year. The clinical manager reports that cleaning staff have also completed a dementia qualification and have been very helpful in assisting residents with challenging behaviours. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale and skill mix policy is in place. Sufficient staff are rostered to manage the care requirements of the residents. The facility covers three floors with an elevator and stairs for access. The facility had 123 out of 124 residents living at the facility with a recent vacancy from a double room. There were no empty rooms. Staff RNs are rostered to work 12-hour shifts. Staffing levels described below are in addition to the clinical manager/RN who is rostered Monday – Friday. There are a total of two RNs and seven caregivers rostered during the night shifts.  The dementia unit (27 residents) and a dual-purpose wing (14 rest home and 8 hospital) are on the ground level. A unit coordinator and a staff RN cover this floor from 7am to 7pm and one RN covers the 7pm to 7am shift. The RNs on the ground level are supported by adequate numbers of caregivers. The first floor (hospital only) consists of two wings (47 residents) and is rostered with two RNs (7am to 7pm) and one RN from 7pm to 7am. There are sufficient numbers of caregivers rostered for the first floor. The second floor (nine hospital and eighteen rest home) is staffed with an EN Monday – Friday and adequate numbers of caregivers. The second floor is supported by the RNs who attend to residents on the second floor twice per shift. The facility manager reported that only high functioning hospital level residents reside on the second floor.  Adequate numbers of caregivers are rostered with the Bupa casual pool covering absences. Two activities staff (one who is a diversional therapist) are rostered five days a week. Separate cleaning and laundry staff are rostered.  Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. All admission agreements viewed (including respite) were signed and dated. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy 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. |
| 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 | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. The resident had been assessed as competent to self-administer and had signed a consent form. The medications were stored in a locked cupboard in the resident’s room. There are no standing orders.  The facility uses a robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and senior caregivers administer medications in the hospital, rest home and dementia unit. Staff attend annual education. All staff administering medications have current medication competencies. Registered nurses have syringe driver training completed by the hospice service. The medication fridge temperature is checked weekly. Eye drops are dated once opened.  The facility uses an electronic system. Staff sign for the administration of medications on the electronic system. Twenty-four electronic medication charts were reviewed (eight hospital, eight rest home – including one YPD and eight dementia). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. ‘As required’ medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | CI | A kitchen manager/cook oversees food provision. He is supported by an assistant cook, two part-time cooks and two kitchenhands. All food is cooked on-site in a well-equipped kitchen. The kitchen manager/chef is an approved assessor for kitchen modules and undertakes refreshers for staff. Kitchen staff had attended training in safe food handling and chemical safety. The kitchen manager is also a member of the health and safety and quality committee.  At interview, the kitchen manager described that the RN completes each resident’s nutritional profile on admission with the aid of the resident and family. There is a four-weekly seasonal menu developed by a dietitian (last reviewed June 2017 at organisational level). Diets are modified as required. Likes/dislikes, puree diets and special diets are catered for. Alternatives are offered. Resident’s specific cultural needs are met. Food served on the day of audit was hot and well presented. Equipment is available on an ‘as needed’ basis. Residents requiring extra support to eat and drink are assisted and this was observed during lunch.  The kitchen manager works closely with the clinical manager to manage weight loss, providing feedback on consumption, adding high protein and energy foods, small and frequent meals. Feedback is encouraged daily via individual or at resident meetings and annual surveys. The residents interviewed spoke highly about meals provided and they all stated that they are asked about their food preferences.  Fridge/freezer, dishwasher and end cooked food temperatures are monitored daily. Food safety information and a kitchen manual are available in the kitchen. The kitchen and the equipment are well maintained. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away. Material safety datasheets are available and there is a locked chemical storage room. A cleaning schedule is maintained.  Food audits are carried out as per the yearly audit schedule. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed on admission and reviewed at least six-monthly or when there was a change to a resident’s health condition. The interRAI assessment tool is implemented. InterRAI assessments had been completed for all long-term residents whose files were sampled. Care plans sampled were developed on the basis of these assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provided detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative’s health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents’ needs changed.  Resident falls are reported on accident forms and documented in the progress notes.  Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.  Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently eighteen wounds and two pressure injuries being treated. Three wounds have had input from the GP and wound care specialist. There are skin mapping graphs and photos of six wounds.  One resident has a PEG in situ and one has a right jugular tunnel line. There are protocols for the care of these in place and assistance from specialist nurses at ADHB is available if required.  The facility is proactive regarding weight loss and uses food and fluid recording charts if required. Weight is recorded monthly or more often if needed. Referral to the dietitian will be made by the GP when appropriate. Supplements may be initiated.  Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit behaviours that challenge. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a diversional therapist, 32-hours per week. She is supported by an activity assistant who is employed for 40 hours per week. The activity team have access to a Bupa diversional therapy (DT) team at head office and attend the regional DT/activities regional study days with training and education including guest speakers. The DT is a member of the society of diversional therapists and actively networks with other DTs and activities staff.  Each resident has an individual activities programme, which is reviewed when their plan of care is reviewed and as part of their interRAI assessment.  There are two group activity programmes implemented Monday to Friday between the hours of 9 am to 4 pm in all three lounges (the two hospital/rest home lounges and the dementia lounge). All residents can attend activities on offer, which are considered appropriate to their recreational needs. One-on-one time is spent with the four YPD residents to ascertain their individual needs. The DT or activity assistant accompanies these residents on regular weekly outings; shopping trips, out for lunch or to visit a place of their choice (recent visit to the Auckland Air NZ display at the museum). One YPD long-term resident recently went on an outing for the very first time. One other YPD resident helps with the barbeques.  Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme.  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 Catholic church service weekly and some residents attend church services in the community. All residents have the opportunity to go on outings using the service’s bus. A caregiver or activity person accompanies the DT on outings. The DT drives the bus and she has a current drivers licence and first aid certificate.  Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting and resident satisfaction surveys.  Residents and relatives interviewed were satisfied with the activities programmes on offer. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The twelve long-term care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for the rest home and dementia unit and one-monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to wound care specialists and mental health services for older people. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is an effective system of waste management in place. Dedicated staff manage the purpose-built laundry, which provides laundry services for six (including Sunset) Bupa facilities. Chemicals are supplied by an external contractor and stored securely throughout the facility when not in use. Appropriate policies are available along with chemical material safety datasheets. 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. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness, which expires 23 April 2018. 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 an external gardening company. Contracted providers test equipment. Electrical testing of non-hard-wired equipment was last conducted June 2017. Medical equipment requiring servicing and calibration was last conducted June 2017. 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. The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted.  Residents have adequate internal space to meet their needs. There are smaller lounges that YPD residents can utilise. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents’ bedrooms throughout the facility have the resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained. The facility has a 10-seater van available for transportation of residents. Those transporting residents are designated drivers. They hold a current driver’s license and a current first aid certificate.  The secured dementia wing has access to a large lounge, smaller lounges and well maintained outdoor areas. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate toilets and showers (including communal) for residents. The majority of rest home and hospital residents have shared ensuites or shared toilets except for eight rooms (includes one double room) who access communal bathrooms. The rooms sharing a toilet only each have a hand basin in the room. All residents in the dementia wing use one of three communal showers and toilets. Separate visitor and staff toilet facilities are available in all wings. Water temperatures are monitored and temperatures are maintained at or below 45 degrees Celsius. Fixtures fittings and flooring are appropriate and 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 | There is adequate space in all bedrooms for residents and staff. Caregivers confirmed they could move freely to provide cares and there is enough space to move mobility equipment safely. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. The residents interviewed stated they are happy with their rooms. Dementia resident rooms are spacious and personalised. |
| 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 | The service has a main lounge and dining area in each unit. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout the facility. Residents can move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements, which allows wheelchair access. Activities occur in the main lounges and residents can access their rooms or smaller lounges for privacy when required. On the day of audit residents in the dementia wing were observed to be walking freely about, some were making toasties with the activities assistant, others were doing artwork. Residents stated that they are happy with the layout of the facility. |
| 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 cleaning supervisor cleans the facility. There is a team of five cleaners, who cover a seven-day service. The cleaners have access to the appropriate equipment and chemicals. Cleaning equipment and cleaning chemicals are stored securely when not in use. The laundry manager oversees laundry services with a team of eleven laundry staff. Laundry is completed for six Bupa sites at Sunset. The internal auditing system and the satisfaction surveys monitor cleaning and laundry services. Corrective actions are signed off once completed. Cleaning and laundry 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 appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation scheme dated 20 November 2014 in place. There is a comprehensive civil defence and emergency procedures manual in place. Civil defence kits on each floor are readily accessible in a storage cupboard. The kits include an up-to-date register of all residents’ details. The facility is well prepared for civil emergencies and has emergency lighting and BBQs. There is a generator. The kitchen has both electric and gas power. A store of potable emergency water is kept. An emergency food supply, sufficient for five days, is kept in the kitchen. Extra blankets are also available. Hoists have battery packs and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders are available for use in the event of a power failure. There is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least five days stock of other products such as medicines, continence products and personal protective equipment is held on-site. There is a store cupboard of supplies necessary to manage an outbreak of infection. All key staff hold a current first aid certificate. The facility is secured during the hours of darkness. Staff are security conscious. An external security firm monitors the facility overnight. Appropriate training, information and equipment for responding to emergencies are provided. Staff training in emergency management occurs. The latest fire evacuation was held on 22 May 2017. Fire evacuation drills are held at least six-monthly and usually more frequently to ensure all staff are well trained. The call bell system is electric and available in all areas and there are indicator panels in each area. During the tour of the facility, residents were observed to have easy access to the call bells. Residents spoken to stated that their bells are answered promptly. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. The facility has thermostatically controlled wall mounted heaters in each resident room (except dementia wing) and heat pumps in communal areas. There are overhead heating units in the bedrooms in the dementia wing. All bedrooms and communal areas have at least one external window. The indoor temperatures were pleasant and warm. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control (IC) 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 coordinator is a registered nurse (clinical manager) and she is responsible for infection control across the facility. The IC 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 Sunset. The quality/infection control committee consists of a cross section of staff and there is external input as required from general practitioners, and the local community laboratory. There have been no outbreaks since 2015. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Bupa Sunset. The IC coordinator has maintained best practice by attending IC updates (Bug control last February 2017). The IC team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IC manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the IC team, training and education of staff and scope of the programme. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IC coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. IC training was last provided July 2015.  The IC coordinator has received education by an external provider to enhance her skills and knowledge. The IC coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.  A number of toolbox talks have been provided including (but not limited to) managing and preventing respiratory infections. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC coordinator uses the information obtained through surveillance to determine IC activities, resources and education needs within the facility.  Internal IC audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and community laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  Effective monitoring is the responsibility of the IC coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.  Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. There has been a significant reduction in the number of urinary tract infections.  All infections are documented monthly in an infection control register which is now electronic (from August 2017). |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were eleven hospital level residents with restraints and two residents using an enabler.  Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on RMSP/enablers is provided annually.  One resident who was using bedrails as an enabler was selected for review. An enabler assessment was completed. The resident had voluntarily requested bedrails for their safety and was able to inform staff when the enabler should be removed. Enabler use for this resident was reviewed six-monthly. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (staff RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. Two files for residents using restraints (bedrails) were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented and include bed rails (seven) and lap belts (five) with one resident using both. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident’s restraint care plan, evidenced in both residents’ files where restraint was in use. An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures.  Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify two hourly checks (at a minimum) were sighted on the monitoring forms for both residents using restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed three-monthly and were evidenced in both files reviewed. Restraint use is discussed in the RN and quality meetings and was confirmed in the meeting minutes. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. The restraint coordinator reported that she participates in these meetings. |

# Specific results for criterion where corrective actions are required

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

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

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

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| 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 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Several quality initiatives and resident satisfaction survey results reflect best practice. | Sunset Home and Hospital has a long-standing and experienced management team with a stable staff and low turnover. In 2016 the clinical manager was awarded the ADHB Nurse of the Year for aged care and was the NZ finalist in the Bupa global awards for ‘everyday hero’.  The facility provides clinical placements and a supportive training environment for student nurses and healthcare assistants, which has now extended to include medical students and paramedic students.  In addition to a physiotherapist, a physiotherapy assistant provides passive exercises for bed-bound residents twice per week. Successful outcomes have included three residents who were previously either wheelchair bound or immobile and are now ambulating with assistance.  Eleven of the twelve RNs have completed their interRAI training. Six RNs and two ENs have submitted their professional development recognition portfolio (PDRP) folders and the remaining six RNs are scheduled to submit their folders by October 2017. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Falls have reduced significantly in the dementia unit in 2017. The rate of challenging behaviours is also consistently below the benchmark and is noted in particular for dementia level residents. | A number of strategies have been implemented to reduce the number of falls. Staff are regularly informed via a newsletter developed by the clinical manager to keep them informed regarding the number of falls. Caregivers are assisted to the lounge to supervise residents. Red falls stickers are placed on bedroom doors and walking devices to identify those residents who are at risk of falling. Cleaning staff have completed their Careerforce training which has allowed them to assist with residents’ cares and provides distractions and interventions to minimise falls. The staff celebrate days where there have been no falls in their wing. Falls have reduced significantly in 2017 in the dementia unit with only one month with rates above benchmark (16.1) and six months below benchmark (8).  The dementia unit in particular has implemented a number of strategies to reduce the incidents of challenging behaviours. The activities programme addresses times when residents are most challenging (sun-downing), and staff working in the dementia unit are proficient in dealing with residents with challenging behaviours. The number of incidents of challenging behaviours in dementia has not exceeded the benchmark for the entire 2017 year. Observations in the unit reflected a calm atmosphere. Interviews with four families (dementia level) confirmed that staff are excellent at managing challenging behaviours. |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | In 2016, the service identified an area to improve on resident satisfaction with food services. The service sought increased feedback from residents regarding likes and dislikes and to plan meals accordingly to prevent complaints. Residents were asked for feedback and the kitchen manager sought feedback at every mealtime and in resident meetings. The outcome of this has resulted in increased in compliments over the last two years. The staff interviewed reported a strong emphasis on increasing resident satisfaction with food services at the forefront of their focus. | The service conducts annual resident satisfaction surveys. The survey measures all areas of service delivery including food services. In 2016, the service identified an area of improvement in resident satisfaction was required for food services. There have been improvements noted across the food service.  New initiatives were implemented. The service encourages resident feedback. The kitchen manager visits wings during dining times to seek feedback, alternative options are offered at all meals (can have eggs for breakfast), buffets were introduced once a week in Kauri (rest home/hospital) wing. The kitchen manager reviews each season’s feedback and implements changes as per resident request (buffets, more fresh foods and different salads in summertime, and barbeques). Cultural needs are met. Indian food is cooked daily and once a fortnight there are opportunities for Indian residents and their families to cook Indian food together, an Asian resident receives Asian food specific to her culture on a daily basis, other cultures are catered for too. The AC interviewed stated one YPD resident facilitates barbeques. Residents involved in meal planning for special events are organised and any special requests are discussed at resident meetings.  The staff interviewed advised that residents and families were very responsive, and they appreciated the opportunity to discuss and feedback as a group or individually, directly with the managers, nurses and cook, any matters of concern, likes or dislikes. This led to residents making suggestions for improvements. When new residents enter the service or residents raise concerns about the standard of meals the cook goes to meet with them to discuss individual likes/dislikes.  The food service is very responsive to resident’s requests for favourite meals, such as bacon and eggs for breakfast, fish and chips or exchanges for any dislikes.  Residents have added more compliments over the last year. Resident meetings are more positive and less focused on food complaints and are now about food alternatives and likes/dislikes. Residents interviewed stated they were very happy with the food services and felt comfortable to raise any concerns or suggestions. Overall satisfaction was maintained (87% in 2016 and 86% in 2017), there was an increase in compliments (five in 2016 and nine in 2017 to date), there were less referrals to the dietitian for weight loss (eight referrals in 2015, four in 2016 and two in 2017 and six of these residents put on weight).  Staff interviewed could describe the positive impact on the resident's satisfaction with food services since seeking active participation and feedback from residents. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | There is a robust infection control process in place. Monitoring in each area is completed monthly and is reported to clinical and quality/health & safety meetings. Monthly organisational IC benchmarking meetings are also held where trends are reviewed. | Infection-control data review documented a high urinary tract infection (UTI) rate amongst residents (rest home, hospital and dementia) in mid to late 2016. Analyses of benchmarking data reflected an overall infection rate that has trended downward for the past year.  The service implemented a process of staff education to ensure staff awareness of IC practices. Quality initiatives are in place to reduce infections (regular checks all residents, two hourly fluids, hygiene care focus with oversight by RNs, introduction of lounge carers with two in each lounge at all times, education regarding early warning signs, ongoing on the floor ‘tool box’ education talks).  This resulted in a significant reduction in UTIs in the first quarter of 2017. UTIs remained below benchmarked levels (1-1.2). At the time of audit, the UTI rate of 0-1 UTIs per 1000 occupied bed days continues to be below the benchmark in all areas (hospital, rest home and dementia care). |

End of the report.