

Bupa Care Services NZ Limited - Tasman Care Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Tasman Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 October 2017 End date: 5 October 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:	70

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Tasman Care Home is part of the Bupa group. The service is certified to provide rest home and hospital level care for up to 72 residents. On the day of audit there were 70 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 a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

The care home manager has been in the role since July 2016. He is supported by a clinical manager who has been in the position for two months.

There are quality systems and processes being implemented that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to Tasman Care Home. Quality initiatives are being implemented, which provide evidence of improved services for residents. There is an orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

A continuous improvement has been awarded around implementation of quality goals.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Tasman Care Home endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. There is evidence that residents and family are kept informed. The rights of the resident and/or their family/whānau to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		All standards applicable to this service fully attained with some standards exceeded.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. Tasman Care Home is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. Quality and risk

performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrated a culture of quality improvements. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. The staffing levels meet the needs of residents. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

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.
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Registered nurses are responsible for each stage of service provision. The care plans are resident, and goal orientated and reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months. Two activities staff implement the activity programme for the facility. There are policies and procedures to guide staff in safe administration of medication. Medication charts are reviewed three monthly by the general practitioner. Residents' food preferences and dietary requirements are identified on admission and all meals are cooked on-site. This includes consideration of any particular dietary preferences or needs.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times. There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The building has a current building warrant of fitness. Each resident room has either a shared ensuite or single ensuite. All ensuites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment. There is a large open plan lounge/dining area on each floor. Appropriate training, information, and equipment for responding to emergencies is provided at induction and is included in the annual training programme. The call bell system is available in all areas with visual display panels. There is one external courtyard/garden area and two floors have covered decks.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had one resident using a restraint and no residents with an enabler. Staff have been provided with training around restraint minimisation. Assessed risks are documented in care plans. Ongoing restraint assessments, monitoring and evaluation occurs. The service and organisation regularly review restraint use and strive to minimise the use of restraint.

Infection prevention and control

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

Standards applicable to this service fully attained.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	1	100	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with ten care staff (four caregivers, four registered nurses (RN), one activities coordinator and one activities assistant), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The informed consent and resuscitation policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Completed resuscitation forms were evident on all resident files reviewed. There is evidence of general practitioner (GP) and family discussion regarding a clinically not indicated resuscitation status. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for daily cares. Enduring power of attorney evidence is sought prior to admission, medical competence assessment for activation EPOA is obtained, and both are kept in the resident's file. Caregivers interviewed were familiar with the code of rights and informed</p>

		consent and they described how they implement choice and consent on a daily basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly and relative meetings bi-monthly. Regular newsletters are provided to residents and relatives.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Thirteen complaints were made in 2016 and 16 complaints received in 2017 year-to-date. All complaints reviewed had documented evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed have been followed-up and implemented. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, clinical manager and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Nine residents (four rest home and five hospital level) and two relatives (one rest home and one hospital level) interviewed, report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff received training in July 2017.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there was one resident that identified as Māori living at the facility. Māori consultation is available through the documented Iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic, last occurring in June 2017. Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A house general practitioner (GP) visits the facility twice a week. The service receives support from the district health board (DHB). Physiotherapy services are provided on-site, eight hours per week. The service has a physiotherapy assistant that works 40 hours per week. There is a regular in-service education and training programme for staff. A podiatrist is on-site every six-weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>Bupa has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. Tasman Care Home is benchmarked against the rest home and hospital data. If the results are above the benchmark, a corrective action plan is developed by the service. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>Seven of nine RN's have completed interRAI training. One has recently commenced training. One RN is a qualified Career Force assessor and Level 3 PDRP proficient.</p> <p>In 2017, they received positive feedback from their Customer Satisfaction Survey. They attained a Net Promoter Score of +48, one of the best in the Bupa group. Overall satisfaction was an excellent rating- 54%, and a Good rating 42%.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed from September 2017, identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>CI</p>	<p>Tasman Care Home is a Bupa residential care facility. The service is certified to provide rest home and hospital (geriatric and medical) level care. There are 72 dual-purpose beds located across three levels in the care facility. At the time of the audit there were 70 residents, 28 rest home level residents and 42 hospital level residents. One hospital level resident was on respite and one hospital level resident was on the interim care scheme district health board (DHB) contract. Level one, included 24 of 24 residents, (21 rest home and three hospital residents), level two, included 23 of 24 residents, (three rest home and 20 hospital level residents) and level three, included 23 of 24 residents, (four rest home level and 19 hospital level residents).</p> <p>A vision, mission statement and objectives are in place. Annual quality/health & safety goals for 2017 for the facility have been determined, which link to the overarching Bupa strategic plan. Tasman Care Home is part of the Northern One group. The operations manager teleconferences with the managers from the region fortnightly to discuss the organisational goals and their progress towards these. A monthly report is prepared by the care home manager and sent to the operations manager and the Bupa continuous service improvements (CSI) team on the progress and actions that have been taken to achieve the Tasman Care Home quality goals. The operations manager completes a report to the director of care homes and rehabilitation.</p> <p>The care home manager at Tasman Care Home has been in his role since July 2016. He has extensive experience in managerial roles. He is supported by a clinical manager who has worked at Tasman Care Home since July 2016 and in the clinical manager position for two months. Staff spoke positively about the support/direction and management of the current management team. The operations manager supports the management team and was present during the audit along with a relieving care home manager.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical manager or the relieving care home manager steps in when the care home manager is absent. The operations manager who visits regularly supports the clinical manager and relieving care home manager.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Tasman Care Home has a quality and risk management system that supports the provision of clinical care and support. Bupa has systematically been rolling out an electronic incident reporting system (Riskman) throughout the care homes. By the end of October 2017 Riskman will be implemented in all the care homes nationally. Quality and risk data results are discussed in the quality/staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. 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 (Smile) is in place, which is linked to the overarching Bupa National Health and Safety Plan. Falls prevention strategies are in place that includes the analysis of falls incidents, including increasing staff at high risk falls times at hospital level care and the identification of interventions on a case by case basis to minimise future falls. There was an annual resident/relative satisfaction survey completed in June 2017. The overall satisfaction rate for 2017 resident/relative satisfaction survey was 96%.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations were completed for resident falls reviewed that resulted in a potential head injury. Incidents are benchmarked and analysed for trends. The managers were aware of their requirement to notify relevant authorities in relation to essential notifications. One section 31 notification was completed for a stage four pressure injury in 2017 (sighted).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files (one clinical manager, one unit-coordinator, one RN, two caregivers, one kitchen manager, one activities coordinator and one maintenance officer) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN, support staff) and includes documented competencies. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this, they are then able to continue with Core Competencies Level 3, unit standards. These align with Bupa policy and procedures. Eighty four percent of the total staff have attained at least one Bupa Personal Best certificate. A total of 78% of caregivers have attained a Careerforce qualification.</p> <p>There is an annual education and training schedule being implemented for 2017. Initiatives were introduced to improve the number of education sessions and the number of staff attendance. Staff interviewed confirmed that there is sufficient training provided and that the sessions are at suitable times. Opportunistic education is provided via toolbox talks. There are eleven RNs (including the clinical manager and unit coordinator) and seven have completed interRAI training with one currently in progress of completing. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for registered nurses including insulin administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and medication competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is an organisational staffing policy that includes skill mixes. Tasman Care Home has a four-weekly roster in place which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. The care home manager and clinical manager are both full time and available during weekdays. The care home manager is on-call after hours for any organisational concerns and the unit coordinator and a senior RN share the on-call for any clinical issues. A model of nursing care and caregiver roster was introduced to ensure staff have a greater level of security of hours whilst allowing the roster to be responsive to occupancy. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers support the RNs.</p> <p>The facility is divided into three levels of 24 beds. On level one (24 residents - 21 rest home and three hospital residents), there is one RN on duty on the morning and afternoon shifts. There are also two caregivers on duty on the morning and afternoon shifts, and one on the night shift. On level two (23 residents, - three rest home and 20 hospital level residents), there is one RN is on duty on the morning and afternoon shifts, and one on the night shift. There are three caregivers on duty on the morning and afternoon shifts, and one on the night shift. On level three (23 residents, - four rest home level and 19</p>

		<p>hospital level residents), there is one RN on duty in the morning and afternoon shifts, and one on the night shift. There are four caregivers on duty in the morning, three in the afternoon and one on the night shift.</p> <p>Staff interviewed confirmed that staffing was sufficient. Residents and relatives interviewed confirmed bells were answered in a timely manner and staffing was sufficient.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident 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. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Resident's needs are assessed prior to entry by NASC and on entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. The care home manager facilitates this, and the required information related to entry to the service documented by the registered nurse. Residents and families interviewed stated they received an information pack at entry and were able to speak with the manager if they had any questions regarding the admission process.</p> <p>There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission. The service provides services under the interim care scheme where residents enter the service for short-term stay after discharge from the local hospital. One (interim care scheme) resident file reviewed showed that care requirements were documented in the resident's file. Nine resident files (five hospital including one interim care, one respite and four rest home were reviewed). All files sampled had signed service agreements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service uses two weekly robotic packs. Medication charts are electronic. Staff sign for the administration of medications on the electronic administration record. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded are fed back to the supplying pharmacy. There is a list of standing-order medications approved by the GP. Registered nurses (on all three levels) and medication competent care staff are responsible for medication administration. Competency tests are completed annually. Registered nurses have completed syringe driver competency. Medication error reporting occurs, and staff completed medication management training.</p> <p>Medication policies align with accepted guidelines. Medications are stored in locked trolleys on each of the three levels. Controlled drug checks are completed weekly. There were three residents self-medicating at the time of the audit. Residents' medicine competencies were completed, and medication administration records were maintained. Medication profiles are legible, up-to-date and reviewed at least three monthly by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen manager/chef oversees food provision. He is supported by two cooks and two kitchen assistants. All staff have completed food safety training. There is a four-weekly rotating summer and winter menu. The menu has been reviewed and approved by an external dietitian at organisational level. All food is cooked on-site and delivered to rest home, hospital residents and serviced apartments via bain maries. Each floor has a locked kitchenette that has a servery out to the dining areas. Each kitchenette includes a servery area, fridge and dishwasher. Food is transported from the main kitchen to each kitchenette via a service lift. Kitchen fridge, food and freezer temperatures are monitored and documented daily. A cleaning schedule is maintained.</p> <p>Nutrition assessments are completed, and weight monitoring occurs. Resident files reviewed included dietitian input. The residents' nutritional profiles are communicated to the kitchen and the kitchen manager/chef interviewed was aware of residents' dietary requirements. Special equipment such as 'lipped plates' and built-up spoons are available as required. The kitchen caters for special diets and textures and accommodates cultural preferences (Korean food is cooked daily). The kitchen manager/chef seeks individual feedback from residents at meal time and alternatives are offered. Feedback is also via resident meetings and annual surveys. Residents and families interviewed were very happy with food services.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available or, if the person has health needs that are not able to be provided by the facility. If a potential admission was declined entry, the consumer and where appropriate their</p>

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		family/whānau of choice, is informed of the reason for the decline and provided with other options where they can access services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	A comprehensive initial nursing assessment and care plan is completed in all files sampled. Personal needs, outcomes and goals of residents are identified. Resident files sampled demonstrated that a range of assessment tools (nursing risk assessments and interRAI) were completed in resident files and reviewed at least six-monthly including (but not limited to); falls, pressure injuries and continence. Nutrition and pain are assessed on admission and 'as needed' and weights and general observations are monitored on a weekly to monthly basis dependant on needs. Assessment process and the outcomes are communicated to staff at shift handovers, via progress notes, initial assessment and care plans. Residents and families interviewed stated they were informed and involved in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. All nine care plans reviewed were evidenced to be up-to-date. All long-term care plans had an individualised care plan that covers all assessed needs. The respite and interim care files reviewed included regularly updated short stay care plans. Specific resident medical needs were also covered in care plans reviewed. Long-term care plans demonstrated service integration. Assessments and care plans are comprehensive and include input from allied health including dietitians, DHB wound nurse specialist, physiotherapy and podiatry.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans reviewed include documentation that reflect resident needs. In files sampled wound care plans, pressure injury prevention, diabetes specific plans, falls prevention, nutrition management and pain management plans were evident. The use of short-term care plans was evident. Where resident's needs changed the LTCP was updated. The care being provided is consistent with the needs of residents, this is evidenced by discussions with residents, family and staff. The GP interviewed stated the facility immediately applied advice regarding changes in care and was happy with the quality of care provided. There is evidence of referrals to specialist services such as podiatry, physiotherapy, dietitian and DHB wound nurse specialist. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

		<p>Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for twelve residents with wounds. Two residents have pressure injuries. All wounds have been assessed, reviewed and managed within the stated timeframes. On interview, the four RNs and the clinical manager stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an activities coordinator (a qualified diversional therapist) and an activities assistant. The activities coordinator develops the activities programme and each resident receives a copy of the monthly plan. The plan is easy to read and printed in large type to assist those residents who are visually impaired. Residents from any area can attend any of the activities offered. Activities are planned that are appropriate to the functional capabilities of residents. For those residents who choose not to or are unable to participate, one-on-ones are provided which include hand massage, talks and music. Each resident has an individual activities assessment completed on admission. Care plans are developed from information gathered in assessment. In all files reviewed interventions for activities were detailed for the specific resident and were age appropriate. The care plans reviewed had been evaluated six monthly at the same time as the long-term care plan.</p> <p>Activities are offered on all three levels of the home and include two activities before lunch and one after lunch. There are outings weekly for each area, entertainment and a daily exercise programme. The PT assistant provides two 'chair pedalling' sessions a week and includes those residents who are at risk of falls. School children and kindergarten children visit. There is pet therapy. There are monthly 'tool box' sessions with support and resources provided by head office. Staff and residents are preparing for 'Tasman's got talent'. Residents choose 'staff of the month' and enjoy celebrating a monthly theme. Some residents attend activities in the community. Residents fed back via resident meetings in January 2017 that they wanted more activities. At the request of residents, the facility has joined 'Waitakere Sports' where they host or visit to provide events. This has become part of the programme and every fortnight up to nine residents attend. All residents and families interviewed stated they were happy with the activities available and are given a choice regarding attendance.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans are reviewed and evaluated by the RNs six-monthly, or when changes to care occur. More frequent reviews were undertaken as residents' care needs changed or after implementation of short-term care planning. Short-term care plans reviewed included wound care, infection and mobility. All short-term care plans reviewed, evidenced evaluation of the interventions and were signed and dated by the RN when issues had been resolved. Care staff interviewed stated they were informed of any</p>

		changes to resident care.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral forms and documentation are maintained on resident files. There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent. The service has a contract to provide interim care. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Follow-up occurs as appropriate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures in place for the management of waste and hazardous substances. There is a spill kit available for the facility. All accidents/incidents are required to be reported on the accident report form, which is in turn investigated by the manager and reported to the Bupa health and safety coordinator. Material safety datasheets and correct PPE are available in the sluice rooms on each floor. Each sluice room on each floor has a sanitiser. Sharps containers are kept in the treatment room on each floor. A hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Tasman Care Home has a current building warrant of fitness (expires 16 June 2018). Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. The maintenance person is currently in the process of orientation and is available from Monday to Friday. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly, and these are maintained at (or just below) 45 degrees Celsius.</p> <p>The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted. There is sufficient space to allow residents to move around the facility freely. The hallways have handrails 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 resident's own personal belongings displayed and all have full ensuites. External areas and garden areas are maintained and well presented. Level paths to</p>

		the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All three levels have a mobility toilet near the lounge. Each resident room has either a shared ensuite or single ensuite. All ensuites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment. Shared ensuites have locks and green/red lights to identify whether or not it is occupied. Staff can open these in an emergency, if necessary. There is a mobility bathroom with a shower bed on each level.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	Residents rooms on all three levels are large and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and communal toilets/bathrooms in all areas. Residents requiring transportation between rooms or services can be moved from their room by stretcher, lazy boy or wheelchair.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There is an open plan lounge/dining area on each level. The facility has a whānau room and a small library that can be used by relatives and residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is</p>	FA	There are policies and procedures around management of laundry and cleaning services. The laundry service is completed off-site (daily) at another Bupa facility. There are separate areas for storage of clean and dirty laundry. There are dedicated cleaning staff. Each floor has a sluice room. Cleaning and laundry services are monitored and audited for effectiveness. Chemicals are stored securely. Staff received training around chemical safety. Residents interviewed stated they were happy with the laundry service provided.

being provided.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. The facility has an approved fire evacuation scheme dated 30 May 2014. Fire evacuation drills take place every six months, with the last fire drill occurring on 6 September 2017. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup.</p> <p>There are civil defence emergency/disaster wheelie bins on each level of the building. Pandemic/outbreak supplies are available. There is sufficient water stored to ensure for three litres per day for three days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Tasman Care Home is appropriately heated and ventilated. There are ceiling heaters in resident rooms and ceiling heat pumps in hallways and lounge areas. There are heat control panels in individual rooms. There is plenty of natural light in the new rooms and all have windows. The maintenance person monitors room temperature, ensuring that an even and comfortable temperature is maintained. Tasman Care Home is a smoke free facility. No staff, residents and visitors are allowed to smoke in the facility or Tasman Care Home grounds.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. The infection control (IC) programme is implemented and has been linked to the quality programme. There is a job description for the IC coordinator and clearly defined guidelines. The infection control committee is active and IC matters discussed at the staff and quality meetings. The IC programme is reviewed annually at the Bupa office. The facility has developed links with the GP, local laboratory and public health authorities. IC audits have been conducted and education has been provided for staff.</p>
<p>Standard 3.2: Implementing the</p>	FA	<p>There are adequate resources to implement the infection control programme at Tasman Care Home.</p>

<p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>The infection control committee is made up of a cross section of staff from all areas of the service and meet two-monthly. External resources and support are available when required. The IC coordinator is supported by the Bupa office through the regional IC group. Infection prevention and control is part of staff orientation and induction.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two-yearly, by Bupa.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The clinical manager is the infection control coordinator and he is responsible for coordinating/providing education and training to staff. He completed IC training in August 2017, and is suitably skilled and trained to manage infection prevention and control matters. He facilitates IC training for all staff, and staff interviewed confirmed current knowledge around IC practices. There have been no outbreaks since the previous audit.</p> <p>The orientation package for new staff includes specific training around hand washing and standard precautions.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and laboratory that advise and provide feedback/information to the service.</p>

<p>specified in the infection control programme.</p>		<p>Systems in place are appropriate to the size and complexity of the facility. There is an outbreak management kit. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. All infections are recorded electronically and included for benchmarking with other Bupa facilities. Corrective actions are established where infections are above the benchmark.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had one resident using a restraint (bed rail) and no residents with an enabler. Staff training around restraint minimisation was last completed in September 2017.</p> <p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had one resident using a restraint (bed rail) and no residents with an enabler. Staff training around restraint minimisation was last completed in September 2017.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Only staff that have completed a competency assessment are permitted to apply restraints. Competency assessments expire annually and are renewed by the restraint coordinator. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is the clinical manager who has a signed job description, and understands the role and his accountabilities.</p> <p>Only staff that have completed a competency assessment are permitted to apply restraints. Competency assessments expire annually and are renewed by the restraint coordinator. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is the clinical manager who has a signed job description, and understands the role and his accountabilities.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	<p>FA</p>	<p>Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There was a restraint assessment tool completed for the one hospital resident requiring bedrails for safety. The care plan was up-to-date and provides the basis of factual</p>

<p>undertaken, where indicated, in relation to use of restraint.</p>		<p>information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Falls risk assessments are completed six monthly and interRAI assessment identifies risk and need for restraint.</p> <p>Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There was a restraint assessment tool completed for the one hospital resident requiring bedrails for safety. The care plan was up-to-date and provides the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Falls risk assessments are completed six monthly and interRAI assessment identifies risk and need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The one resident file reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed of one hospital resident with restraint, identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input. A restraint register is in place, which has been completed for the one resident requiring restraint.</p> <p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The one resident file reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed of one hospital resident with restraint, identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input. A restraint register is in place, which has been completed for the one resident requiring restraint.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three-monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their care plan review. Evaluation timeframes are determined by risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the Regional Restraint Approval group and information is disseminated throughout the organisation.</p> <p>Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the Regional Restraint Approval group and information is disseminated throughout the organisation.</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The service introduces and evaluates quality goals annually. Their 2017 annual Quality and Health and Safety Goals include: (i) Moving and Handling: Focus on the effect of moving and handling hazards and embed the actions to provide a safer environment and lessen the risk of injury to staff, residents and others. Almost all staff have attended a Moving and Handling training session. Moving and Handling champion has been appointed and is being trained. (ii) Health and Safety Education: Health & Safety Officer has attended EMA Health and Safety Training. Staff education continues to be actioned. (iii) Reduce resident falls by 50%. So far, a 34% reduction has been achieved.</p>	<p>Quarterly the quality goals are reviewed and progress to meeting goals are determined. As a result of the evaluation, strategies are adjusted. The service initiated a corrective action plan around meeting the quality goals. To reduce resident falls, they commenced a Falls Focus committee to look at the trends and determine how they could improve them. They conducted extra Moving and Handling training, including at 3 times of the day, including 10 pm, to capture more qualified and care staff. They have analysed times of the day when falls occur. They have increased staffing during these times at hospital level of care, particularly taking high-risk residents to the communal lounge area and having staff on observation. They have also studied and observed when high-risk residents are hungry or require toileting, as these seem to be triggers for their attempts at standing and subsequent falling. As a result, falls incidents have fallen from a year to date monthly average of 16 down to 9 in August 2017</p>

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End of the report.