

Bupa Care Services NZ Limited - Redwood Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Bupa Care Services NZ Limited

Premises audited: Redwood Home & Hospital

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 9 May 2018 End date: 10 May 2018

Proposed changes to current services (if any): No changes

Total beds occupied across all premises included in the audit on the first day of the audit: 74



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Redwood Home & Hospital is a Bupa facility. The service provides hospital (geriatric and medical), rest home, and dementia and psychogeriatric level care for up to 82 residents. Occupancy on the day of audit was 74 residents.

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

The service is managed by a care home manager who has been in the role for two years and was clinical manager prior to this role. The care home manager is supported by a clinical manager (RN) who oversees clinical care.

There is an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The one shortfall identified as part of the previous audit around quality data remains an area for improvement.

This audit identified further areas required for improvement around: medication management, storage of chemicals and neurological observations.

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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There are annual quality goals for the service that are regularly reviewed. There is a documented quality and risk management system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. There is a staffing policy documented.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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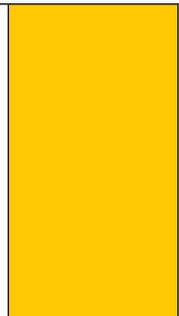
Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior health care assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities staff implement the activity programmes to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents/family were generally positive about the meals. Snacks were available at all times.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The building holds a current warrant of fitness.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and four using enablers at the time of the audit.

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. Surveillance data is undertaken. Infection incidents are collected and analysed, and the information used to identify opportunities for improvements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	2	0	0
Criteria	0	37	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. There are complaint forms available in the foyer. Information about complaints is provided on admission. Interviews with residents (two hospital and four rest home) and families demonstrated their understanding of the complaints process. Staff interviewed (four caregivers, three registered nurses, the clinical manager, the care home manager, one activity coordinator and three activities assistants) were able to describe the process around reporting complaints.</p> <p>A complaints register is being maintained. Five complaints were lodged in 2017, which included both verbal and written complaints. All complaints held in the register included evidence of an investigation, corrective actions (where indicated) and resolutions. One complaint lodged 2016 following a resident death has a documented root cause analysis and robust action plan. There have been no complaints lodged for 2018 year-to-date.</p> <p>Complaints are linked to the quality and risk management system. Discussions with relatives confirmed that issues are addressed promptly and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The care home manager and clinical manager confirmed family are kept informed. Four relatives (one dementia, one hospital, one rest home and one psychogeriatric) interviewed stated they are notified promptly of any incidents/accidents and changes to</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>residents' health status. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents.</p> <p>There is access to an interpreter service as required.</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>FA</p>	<p>Redwood Home & Hospital is a Bupa facility. The service provides hospital (geriatric and medical), rest home, and dementia and psychogeriatric level care for up to 82 residents. Occupancy on the day of audit was 74 residents. There were 16 dementia residents in the 16-bed dementia unit and 15 psychogeriatric residents in the 15-bed psychogeriatric unit. The rest home and hospital wings include four dual-purpose beds. There were 21 rest home level residents, including one resident under a respite contract. There were 22 hospital level residents, including one respite resident. All other residents were under the age-related residential care services agreement.</p> <p>There is an overarching Bupa business plan and risk management plan. Additionally, Bupa Redwoods has developed annual quality and health and safety goals that link to the 2017 resident/family survey results. Goals are reviewed regularly in the quality meetings and included in monthly reports to the operations manager.</p> <p>The service is managed by a care home manager who has been in the role for two years and was clinical manager prior to this role. The care home manager is supported by a clinical manager (RN) who oversees clinical care. The clinical manager has been in the role for two years. The management team is supported by the wider Bupa management team including an operations manager.</p> <p>Staff and family interviewed praised the management team and spoke highly of the leadership and guidance that is provided to staff and support to family members.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</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</p>	<p>PA Low</p>	<p>Bupa has an established quality and risk management programme which is designed so that key components are linked to facility operations. The quality programme includes an annual internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee. Action plans have been implemented and closed out. Meeting minutes documented that results of audit are communicated to staff.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. Incident and accident data results are documented as discussed in staff meetings, quality and RN meetings;</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>this is an improvement from the previous audit. However, there is no trending of data or current benchmarking data available. Meeting minutes are maintained, and staff are expected to read the minutes and sign off when read. Discussions with registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings are held.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. 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. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> <p>Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</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>PA Low</p>	<p>The service collects incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the monthly staff meetings, quality meetings and the two-monthly quality and health and safety meetings.</p> <p>Sixteen incident forms were reviewed for March. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. However, neurological observations had not always been completed for unwitnessed falls and any known head injury, where neurological observations were documented these were not always documented according to the specified timeframes. The caregivers interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. The recent weather included a lightning bolt to the service. This interrupted all telephones, computers and fire alarms. The service implemented their emergency procedures. This included intentional rounding for all resident to ensure their safety and use of mobile phones for communication. There is an incident form documented and a section 31. The service continues to use mobile phones as all communication has not been fully mended. There was a documented debrief for this incident and emergency procedures reviewed as needed.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Nine staff files were reviewed (three RNs, three caregivers, two activities staff and one cook). All files contained relevant employment documentation including current</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>performance appraisals and completed orientations. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of elderly care.</p> <p>There is an annual education and training schedule being implemented which exceeds eight hours annually for each staff member. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the district health board. A competency programme is in place with different requirements according to work type (e.g., support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files).</p> <p>Staff interviewed believed new staff are adequately orientated to the service on employment. Five of the thirteen RNs have completed interRAI training.</p> <p>There is a total of 37 caregivers who work in the dementia and psychogeriatric units. All of these staff have completed the required NZQA dementia standards. The clinical manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local DHB.</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>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RNs, and a clinical and care home manager who respond quickly to after-hour calls.</p> <p>The staffing includes; the care home manager and clinical manager who are both on duty Monday to Friday and on call. An additional RN is on duty Tuesday and Friday to assist with GP rounds and interRAI assessments. A further RN is rostered one shift every two weeks for Careerforce.</p> <p>Hospital (two wings with a total of 22 residents).</p> <p>One RN for each shift. Caregivers - two long shifts and two short shifts plus additional 7.00 am to 10.00 am caregivers if needed for the AM shift. Two long shifts and two short shifts for the PM shift and one caregiver for night shifts.</p> <p>Rest home (two floors with a total of 21 residents)</p> <p>Caregivers - One long shift and two short shifts on the AM shift, one long shift and one short shift on the PM shift and one caregiver on night shift.</p> <p>The RN for the hospital and the clinical manager provides oversight for the rest home.</p> <p>Psychogeriatric unit: (One wing with 16 residents): There is an RN rostered for every shift. Two caregivers on the AM shift; One long shift and one short shift on the PM shift and one caregiver on the night shift.</p> <p>Dementia unit; (one wing with 15 residents)</p>

		<p>There are two long shifts and a 7.00 am to 10.00 am shift on the AM shift. There is one long shift and one short shift on the PM and one caregiver on nights.</p> <p>The RN for the psychogeriatric unit and clinical manager provides oversight for the dementia unit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>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 and all standards were met. There are no standing orders.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. All staff have up-to-date medication competencies. RNs have syringe driver training completed by the clinical manager who has been trained by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p> <p>In the psychogeriatric unit, safe administration was not always observed.</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 service has two cooks and one relief cook. The head cook works 40 hours a week Sunday to Thursday. The second cook works Friday and Saturday. There are five kitchenhands who share the week between them. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served in the units from bain maries/hot boxes. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available.</p> <p>On the day of audit, meals were observed to be hot and well-presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by the Bupa dietitian. Residents and family members interviewed were generally satisfied with the meals.</p> <p>There are snacks available at all times in the psychogeriatric and dementia units.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. Family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident and guidelines for staff were very clear. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being treated in the psychogeriatric and dementia units. These are mainly skin tears. There are currently two wounds being treated in the rest home and hospital. The hospital RN stated that they have access to a wound care nurse specialist if required. There were three PI's - 1x grade 1 and 2 x grade 2. Both grade 2's had been seen by GP and their photos were also in place to monitor improvement.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. Weight loss is monitored in all units but particularly in the psychogeriatric and dementia units. Snacks are available at all times.</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>	<p>FA</p>	<p>There is no diversional therapist. There is one activities coordinator (twenty years' service) who works 35 hours a week, one activities assistant who works 30 hours a week and two activities assistants who work 25 hours a week. All activities staff have Bupa training (including dementia) six monthly and attend workshops. On the days of audit residents were observed doing exercises, having a newspaper reading, answering quizzes, singing and flower arranging.</p> <p>There is a weekly programme in large print on noticeboards in communal areas. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music brain teasers, and walks outside. The dementia and psychogeriatric residents particularly enjoy walks.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>There are interdenominational church services held in the facility on the first Wednesday of each month and Catholic Church members come in to give communion every Thursday. There are van outings for each unit</p>

		<p>weekly. The activities staff who go out on the van all have first aid training. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Matariki, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>The facility has one cat and a pet therapy team visit each Tuesday.</p> <p>There is community input from pre-schools, schools, Kapa Haka group and the RSA. The local marae line dancing group visit monthly</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. This is completed by the activities coordinator with support from the RN. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly. Resident meetings are held two monthly Feedback on activities (both verbal and surveys) was positive from both residents and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The 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 were also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan.</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>	PA Moderate	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels but were not always stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
Standard 1.4.2: Facility	FA	The building holds a current warrant of fitness which expires 11 March 2019. Preventative and reactive

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>maintenance occurs</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at infection control, clinical RN meetings, staff and quality meetings (link 1.2.3.6). Meeting minutes including graphs are available to staff. Trends are identified, and analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</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 service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and four residents with enablers at the time of the audit. Assessments/consents and care plan interventions were documented for two enabler files reviewed.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Redwood collects a variety of clinical data. Incident and accident data results are documented as discussed in staff meetings, quality and RN meetings. This is an improvement from the previous audit. However, there is no trending of data or current benchmarking data available. Therefore, this criterion remains an area for improvement.</p>	<p>There is no documented evidence that quality data collected is analysed and trends identified. There was no current benchmarking data available to assist with identifying trends.</p>	<p>Ensure that quality data is analysed and trended to be able to view progress over time. Ensure benchmarking data is available to assist with analysis and trending.</p> <p>60 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to</p>	PA Low	<p>All incidents and accidents are recorded on the service electronic data base. Incidents for March across the units included two pressure injuries, 18 falls and five skin tears. There is a documented RN review of all incidents. The Bupa policy around neurological observations</p>	<p>Of the falls that required neurological observations; one of one in the psychogeriatric unit did not have any documented, and two of two in the hospital</p>	<p>Ensure that neurological observations are documented according to the</p>

improve service delivery, and to identify and manage risk.		for witnessed and unwitnessed falls has not always been followed.	did not have them documented according to set timeframes.	service policy. 90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	Medications are prescribed electronically. The pharmacy delivers the medications and checks them in with a RN. The pharmacy completes six monthly checks of medications. All medications that are no longer required are returned to pharmacy for disposal. In the psychogeriatric unit, safe administration was not always observed.	In the psychogeriatric unit, the medication trolley was observed to be left unsupervised, with keys and medications on top for ten minutes.	<p>Ensure medications are not left unsupervised and keep keys on person at all times.</p> <p>30 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Moderate	The facility has clear guidelines for staff to follow regarding safe and appropriate storage and disposal of waste, infectious or hazardous substances. Safety data sheets and product sheets are available. Safe and appropriate storage of hazardous substances was not always evident.	<p>1. Chemicals were not in a locked cupboard in a satellite kitchen in the hospital.</p> <p>2. On two separate occasions residents' creams and lotions (including one prescription cream), were left in communal bathrooms in the dementia unit.</p>	<p>1. Ensure all chemicals are stored in a locked cupboard.</p> <p>2. Ensure residents' creams and lotions are not left out in the communal bathrooms.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.