

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

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Rossendale Dementia Care Home & Hospital
Services audited:	Hospital services - Psychogeriatric services; Dementia care
Dates of audit:	Start date: 10 January 2019 End date: 11 January 2019
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:	98



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

Rossendale Home and Hospital is part of the Bupa group. The service provides psychogeriatric and dementia level care for up to 100 residents. On the day of audit there were a total of 98 residents.

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

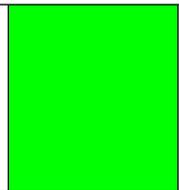
The care home manager has been in the role for 16 months at Rossendale and is supported by a clinical manager (registered nurse), the Bupa regional operations manager and quality and risk team.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for the residents. Implementation is supported through the Bupa quality and risk management programme that is individualised to Rossendale. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This certification audit identified that improvements are required around completion of dementia standards and hot water temperatures.

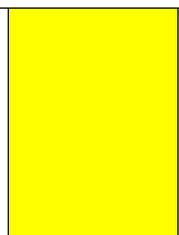
A continuous improvement rating has been awarded around restraint minimisation.

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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Rossendale Dementia Care Home & Hospital 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. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical nurse manager are responsible for the day-to-day operations of the facility. Rossendale Dementia Care Home & Hospital 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 improvement meetings. Goals are documented for the service with evidence of annual reviews. An annual relative satisfaction survey is completed and there are regular relative newsletters.

Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an in-service training calendar in place. Registered nursing cover is provided 24 hours a day, 7 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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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

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

The diversional therapists and activities assistants implement the activity programme to meet the individual needs, preferences and abilities of the residents. 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. Families commented positively on the meals. There are snacks 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 low risk.</p>
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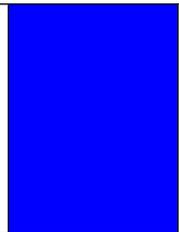
The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services. Cleaning and laundry services are monitored through the internal auditing system. Laundry is completed on-site.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness.

There are shared and single rooms within the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a spacious lounge and dining area and smaller lounges available in each unit within the facility, for quieter activities or visitors. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. The internal areas are ventilated and heated. There is wheelchair access to all areas. The outdoor areas are safe, easily accessible and secure.

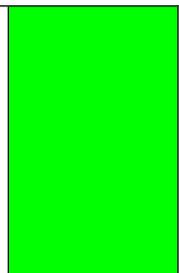
There is an emergency management plan in place and adequate civil defence supplies in an event of an emergency. There is an approved evacuation scheme and emergency supplies. There is a staff member on duty on each shift who holds a current first aid certificate.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. On the day of audit, there were 18 residents using restraint and no residents with an enabler. Restraint management processes are being implemented. The service continues to actively 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer role is shared by three registered nurses who together are 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 officers use 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	47	0	2	0	0	0
Criteria	1	98	0	2	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. Interviews with 21 care staff (10 caregivers, 8 registered nurses (RN), and 3 diversional therapists) reflected their understanding of the key principles of the Code. Staff receive training about the Code which was last completed in April 2018.</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 service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code. Completed resuscitation treatment plan 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 ten caregivers and eight registered nurses (RNs) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed with the admission agreements. Family interviewed confirmed that were fully informed where consent was required.</p>

<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>	<p>FA</p>	<p>Information on advocacy support services is included in the resident information pack that is provided to EPOA and family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with relatives confirmed their understanding of the availability of advocacy support services. Interviews with management and staff confirmed that practice is consistent with policy and staff were aware of how to support relatives to access an advocate when needed. The resident files include information on residents' family/whanau/EPOA and chosen social networks.</p>
<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>	<p>FA</p>	<p>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. Relative meetings are three-monthly.</p> <p>In 2018, the service achieved two "Big Bus Trip" wherein almost half of their residents went to Raglan for picnics and this encouraged residents to be part of the wider community. They have added activities to encourage residents to feel part of the community like "Adopt a grandparent" and invited school children to visit, learn about people living with dementia. The service encourages visits on Saturday and have designed family orientated activities on weekends.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Discussions with relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility.</p> <p>Seventeen complaints received since the last audit (eight in 2017 and nine in 2018) were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Feedback is provided to staff and toolbox talks were completed where required. One of the complaints from 2018 was made through the local District Health Board (DHB) in August 2018. The DHB requested follow up against aspects of the complaint around the admission assessment procedure, clinical review around short-term care plans (STCP), communication and observations, and staff training around de-escalation. A corrective action plan is being implemented with investigation and follow up on the areas of improvement required. This complaint is now closed.</p>

		A complaint made through the HDC in October 2014 has been investigated, followed up and signed off. There was no further action required as confirmed in an HDC letter dated 24 July 2018.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to residents EPOA and family. This information is also available at reception. The care home manager, the clinical nurse manager and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the monthly resident and three-monthly family meetings. Nine relatives (eight PG, including one in the high dependency unit and one dementia care) interviewed, reported that the residents' rights are being upheld by the service. Interviews with family also confirmed their understanding of the Code and its application to aged residential care.</p>
<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. Interviews with relatives were positive about the service in relation to their family members values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training, which was last completed in September 2018.</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. There were eight residents whom identify as Māori living at the facility. The files of the three residents identified as Maori were reviewed and included a specific Māori health care plan. Māori consultation is available through local Iwi links. 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</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the family and/or the resident's representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Family assist to complete 'the map of life' of the resident which provides a breakdown of their life and interests/beliefs. All relatives interviewed</p>

<p>services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. Regular newsletters are provided to relatives. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme. 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 Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. There are clear ethical and professional standards and boundaries within job descriptions. Registered nursing staff are available 24 hours a day, 7 days a week. A main general practitioner (GP) and nurse practitioner each visit the facility two days a week or as needed. The GP is available after-hours 24/7. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided on-site, two days a month. The service has links with the local community. Relatives interviewed spoke positively about the care and support provided.</p> <p>Bupa has robust quality and risk framework that is being implemented at Rossendale. The framework includes standardised policies; an education programme including core competencies for different staff groups; an internal audit and corrective action planning process; benchmarking against similar services types; centralised management of complaints and internal investigation following category one incidents; and surveys (resident/relative and staff). There is a prescribed meeting schedule for services that is also seen to be implemented at Rossendale.</p> <p>In 2018 the service introduced Education Professional Training Days. Two dedicated days were introduced for core in-services and orientation day for new staff. There were also special sessions that included mental health issues. The annual education programme prescribed for the organisation is being implemented at Rossendale. Where attendance at a prescribed in-service is below expected either a 'tool box' session or additional in-service is provided. Tool box sessions are a regular part of</p>

		<p>Rossendale practice and are held in response to either an issue or a planned improvement</p> <p>Bupa Rossendale is the first Bupa Care Home who have undergone MAPA (Management of Actual or Potential Aggression) training. To date, 10 staff had been trained and training will continue in 2019. This project is recognised to be helpful for staff to ensure that they can avoid and be able to handle crisis situations with residents.</p> <p>Nightshifts caregivers are all involved with the Darmouth project. As part of the project staff study, research and learn to understand residents at night time; how to give them good rest and understand their night routine through lights, environment, and lifestyle.</p> <p>The service is supported by the Bupa dementia care specialist.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed identified that family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>There are a number of residents (and staff) from a variety of cultures and family interviewed were particularly complimentary of how staff are able to communicate with residents where English is a second language. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>Family/EPOA are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print.</p> <p>Families/EPOA's of non-subsidised residents are advised in writing of their eligibility and the process for their family member to become a subsidised resident.</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</p>	FA	<p>Rossendale Dementia Care Home & Hospital is part of the Bupa group of aged care facilities. The facility provides psychogeriatric (PG) and dementia level care for up to 100 residents. There were 98 residents at the time of audit including, 11 residents in the 11-bed Totara dementia unit (under the ARRC contract) and 87 residents across the 89 PG level beds (under the Hospital Specialist Services ARHSS contract). The 87 residents at PG level care included 10 residents in the 10-bed high dependency unit, 29 residents in the 29-bed Kowhai PG unit, 18 residents in the 19-bed Rimu PG unit</p>

<p>consumers.</p>		<p>and 30 residents in the 31-bed Pohutakawa unit.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Rossendale Dementia Care Home & Hospital are part of the Northern 2 Bupa region and the managers from this region meet bi-monthly to review and discuss the organisational goals and their progress towards these. The operations manager teleconferences weekly and completes a report to the director of care homes and rehabilitation. A quarterly report is prepared by the care home manager and sent to the Bupa continuous service improvements (CSI) team on the progress and actions that have been taken to achieve the Rossendale Dementia Care Home & Hospital quality goals.</p> <p>The care home manager has been in the role for sixteen months and has five years' experience in care home/clinical management roles with Bupa. She is supported by a clinical nurse manager who has been in the position four and a half years. The operations manager supports the management team. Staff spoke positively about the support/direction of the current management team.</p> <p>The care home manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a hospital.</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 nurse manager who is employed full time, steps in when the care home manager is absent. The operations manager visits regularly and supports both managers.</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>A quality and risk management programme is established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems. 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. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Corrective actions have been implemented when service shortfalls are identified and signed off when completed.</p>

		<p>Riskman has been implemented by Bupa which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries, falls, incidents are completed on the online system. The monthly collation of quality data includes (but is not limited to): resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors. The monthly quality data and trends analysis is provided to staff on the noticeboard in the staffroom. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Falls prevention strategies are in place and are discussed at the bi-monthly falls focus group meeting. Falls prevention initiatives in place include: intentional rounding; sensor mats; post falls reviews; physiotherapist assessment and recommendation; and individual resident interventions.</p> <p>An annual satisfaction survey is completed and the 2018 (August) results demonstrated an 84% overall satisfaction outcome for the relatives. Corrective actions were established in areas identified around room refurbishments, garden improvements, food services and activities. The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer (household manager) who is supported by health and safety representatives. The Health and Safety committee team meet three-monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed regularly.</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. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team immediately and the operations manager. Actions are then followed up and managed. Fifteen accident/incident forms were reviewed for December 2018. Each event involving a resident reflected a clinical assessment and follow up by a RN. Neurological observation forms were documented and completed for six unwitnessed falls with a potential head injury.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications made since the last audit for two pressure injuries, one stage III in August 2018 and one unstageable in January 2019.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>PA Low</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>training and development. Eleven staff files (one clinical nurse manager, two RNs, six caregivers, one kitchen manager and one diversional therapist) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained. 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 (eg, 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.</p> <p>An annual education and training schedule has been completed for 2018 and is in place for 2019. The service provides regular in-service education and dedicated sessions have been provided that address all required areas. As part of the corrective action plan being implemented around a complaint made through the DHB, de-escalation training has been organised for February 2019 (link 1.1.13).</p> <p>There are 15 RNs at Rossendale Dementia Care Home & Hospital and 8 have completed interRAI training. Eighty nine percent of the total staff have attained at least one Bupa Personal Best certificate. A total of 78% of caregivers have attained a national certificate qualification.</p> <p>There are 72 caregivers that work across the PG and dementia units, 56 have completed the required dementia standards. Three of the sixteen caregivers are in process of completing their dementia standards and eight have commenced work within the last 18 months. However, there was no documentation to reflect that five caregivers who have been employed over 18-months had completed dementia standards training.</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 aligns with contractual requirements and includes skill mixes. There is a care home manager and clinical nurse manager who both work full time from Monday to Friday. The care home manager and clinical nurse manager share the on-call duties on a fortnightly basis. Registered nurse cover is provided 24 hours a day, 7 days a week. Separate laundry and cleaning staff are employed seven days a week. Interviews with staff and family members identify that staffing is adequate to meet the needs of residents.</p> <p>The PG beds are split into four separate units (Kowhai, Pohutakawa, Rimu units and the high dependency unit). The splitting of their largest community into two smaller PG communities and re-naming the units is a change since previous audit.</p> <p>The Kowhai PG unit has 29 of 29 residents. There is one RN on duty on the morning, afternoon and night shifts. The RN's are supported by five caregivers on duty on the morning shift, five (four long and one short) on the afternoon shift and two caregivers on the night shift.</p>

		<p>The Pohutakawa PG unit has 30 of 31 residents. There is one RN (unit coordinator) on duty on the morning and a RN on afternoon shifts and one on the night shift (shared with the Rimu unit). The RN's are supported by five (three long and two short) caregivers on duty on the morning and afternoon shifts and three caregivers on the night shift.</p> <p>The Rimu PG unit has 18 of 19 residents. There is one RN on duty on the morning and afternoon shifts and one on the night shift (shared with the Pohutakawa unit). The RN's are supported by three caregivers (two long and one short) on duty on the morning and afternoon shifts and three caregivers on the night shift.</p> <p>The high dependency PG unit has 10 of 10 residents. There is one RN on duty on the morning and afternoon shifts and one on the night shift. The RN's are supported by two caregivers on duty on the morning shift, two caregivers (one long and one short) on the afternoon shift and one caregiver on the night shift.</p> <p>The Totara dementia unit has 11 of 11 residents. There is one enrolled nurse (unit coordinator) on duty on the morning shift. The EN is supported by one caregiver on duty on the morning shift and two caregivers (one long and one short) on the afternoon shift and one caregiver on the night shift. The clinical nurse manager provides RN hours in the dementia unit.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The 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. 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. Individual resident files demonstrate service integration and are legible, dated and signed. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. This includes information around specialist services of a psychogeriatric unit. All resident files reviewed included a NASC approval for the level of care. Information received from the referring agency and the family are used to develop a plan of care prior to the admission of the resident. A communication book is used to ensure all staff are aware of new residents' initial needs.</p> <p>The admission agreements reviewed meet the requirements of the ARCC and ARHSS. Exclusions</p>

		from the service are included in the admission agreement. All ten admission agreements sighted were signed and dated.
<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>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service using the yellow envelope system. A transfer form accompanies residents to receiving facilities and communication with family is made.</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>	FA	<p>There are policies and procedures in place which comply with current legislation. Medicines are stored in accordance with legislation and current guidelines. Medications are pre-packed in blister packs and stored in a locked trolley in the treatment room in each unit. Medicine administration practice complied with the medicine management policy in the medicine round observed. Medications are administered by registered nurses in the psychogeriatric and high dependency wing, and enrolled nurses and medicine competent care staff in the dementia wing. Staff that administer medications complete a medicine competency and medication management annually. Registered nurses undertake extra training to administer syringe drivers.</p> <p>Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular and 'as required' medicines. Medications are checked on admission and on arrival to the facility and discrepancies are reported to the pharmacy. The service does not have standing orders and verbal orders are rarely used as an electronic system is in place. There was no expired stock on-site on day of audit. Eye drops are dated once opened. Medication fridge temperatures are checked daily and temperatures are within acceptable ranges.</p> <p>Staff sign for the administration of medications electronically. Twenty 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>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a kitchen manager working Monday to Friday who is supported by three trained cooks. There is one kitchen hand per shift. All staff have food hygiene 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 directly from the kitchen to the dining room in one PG wing and transported to the other wings in hot boxes. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well-presented.</p>

		<p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. There is an implemented food control plan current until September 2019. 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 and displayed. The four-weekly menu cycle is approved by the Bupa dietitian. Snacks are available at all times in all areas.</p> <p>Families interviewed spoke positively about the availability of snacks at all times and the variety offered.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The Bupa assessment booklet is completed and the interRAI assessment tool is implemented. InterRAI assessments had been completed for all long-term residents whose files were sampled. Care plans sampled were developed on the basis of these assessments. Challenging behaviour assessments were completed for residents with behaviours that challenge that linked to specific dementia care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide details to guide care. Short-term care plans (STCP) are in use for changes in health status. Relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, podiatrist, wound care specialist and mental health care team for older people. The management of behaviours that challenge was documented in the files reviewed including triggers to</p>

		<p>behaviour and interventions to manage outbursts.</p> <p>The care staff interviewed advised that the care plans were easy to follow and assisted them when caring for the residents.</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>	FA	<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. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. The ten resident files sampled all included management of nutrition and monitoring for weight loss. A communication book is used to record residents' appointments, family and medical health practitioner contact, assessments and clinical follow up, and copies of recent ISBAR forms.</p> <p>Resident falls are entered into Riskman 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. Photos of wound progress are taken. There are currently six stage-I facility acquired pressure injuries (four to one resident and two others) one stage-II and one unstageable pressure injuries. There are 22 skin tears across the facility affecting eight residents. All wound documentation was reviewed and noted that the wounds were improving. There is evidence of referral to the wound nurse specialist for a current pressure injury.</p> <p>Monitoring forms are in use as applicable, such as: weight; vital signs; food and fluid intake; restraint checks; half-hourly checks; and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. There is liaison with the mental health for older person's team.</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>There are three qualified diversional therapists and one activities assistant who each work 37.5 hours a week Monday to Sunday. There are two casual activities assistants and one part-time van driver, who support the activities team. The four full-time staff in the activities team are split between dementia and PG units, ensuring there is full-time cover in the PG unit over the weekends. On the days of audit, residents were observed enjoying a fish and chip lunch, music therapy and pet day. Other activities include a move with music programme, ball games, beauty therapy, cooking, kinetic sand activities and many more. The Rossendale activities team share initiatives with other Bupa and</p>

		<p>local dementia units.</p> <p>There is a weekly programme in large print on noticeboards in all unit lounges. 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. This is particularly noticeable in the psychogeriatric units where residents' concentration spans are often short.</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 monthly. Catholic Church members come in to give communion. There are van outings three times weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. Māori staff bring their children for Kapa Haka events and to celebrate Materiki.</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. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly. Resident/family meetings are held three to four-monthly. Activities plans cover 24 hours and include specific interventions tailored to the resident's individual interests. The programme observed was appropriate for older people with mental health conditions and dementia.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The ten long-term care plans reviewed had been evaluated by the RNs six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated at regular intervals 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 residents, and these are 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 members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people, speech language therapist and dietitian. Discussion with the registered nurses us identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

to meet consumer choice/needs.		
<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 regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and 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, goggles and face shields are available for staff. Spills kits are available in all areas.</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>	PA Low	<p>The building holds a current warrant of fitness. There is a maintenance person on-site for 40 hours a week and on call as required. He is supported by a part-time maintenance worker three days a week and contractors are used when required. Repairs and maintenance requests are entered into a log book that is checked daily and signed off as repairs are addressed (sighted). There is a 52-week planned maintenance programme in place.</p> <p>The building has two levels with all resident units' downstairs and offices upstairs. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas, however, temperatures have regularly exceeded acceptable values. The communal lounges, hallways and bedrooms have vinyl flooring as do all utility areas. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade and the psychogeriatric and dementia outdoor areas are safely fenced. There is safe access to all communal areas.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for all levels of care.</p> <p>Since the last audit the manager stated, they have refurbished some bedrooms and divided their biggest community unit into two units. They continue to refurbish bedrooms in all units (communities) as they become vacant. Several of their gardens have been landscaped and this is an ongoing project. They have dedicated a little children playground for visiting mokos/ grandchildren etc.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	FA	<p>There are nineteen double rooms across the three PG units. All bedrooms have hand basins. There are adequate communal toilets/showers available. There is appropriate signage with easy clean flooring and fixtures. Privacy locks indicate whether the toilet/shower is vacant or in use. There are privacy signs on all shower/toilet doors. There are communal toilets near the lounge, dining and</p>

<p>adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>activity areas. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and in larger ones, a hoist if appropriate. Nine relatives interviewed report that they are happy that privacy of their family member is maintained, including in two shared resident bedrooms.</p>
<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	<p>There is sufficient space in each room to allow care to be provided and for the safe use of mobility equipment, shower chairs and hoists. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<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	<p>There is a spacious central lounge and dining room in all units (communities) with each having a quiet/whānau room. Smaller lounges are available for small group or individual activities or for visitors. Tea and coffee making facilities are available. All communal areas are accessible and accommodate the equipment required for the residents. Residents are able to move freely, and furniture is well arranged to facilitate this. Hallways are wide and enable residents to wander safely within their unit. The dining room and lounges accommodate specialised lounge chairs and space is arranged to allow both individual and group activities to occur. All units have outdoor areas with easy access.</p>
<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 being provided.</p>	FA	<p>Laundry is done on-site in a well-equipped laundry. The laundry has a defined dirty and clean area with separate exit and entry doors. There are dedicated laundry staff who work shifts. Personal protective equipment is available in the laundry. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system.</p> <p>The cleaner's equipment was attended at all times or locked away. All chemicals on each of the cleaner's trolley were labelled. Staff are observed to be wearing appropriate protective wear. There are four sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are locked with a keypad when not in use. Cleaning schedules are maintained. Cleaners have attended chemical safety.</p> <p>Relatives interviewed are happy with the laundry and cleaning services provided.</p>

<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>	<p>FA</p>	<p>An emergency/disaster management plan is in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. All registered nurses hold a current first aid certificate. There is an approved fire evacuation plan dated 19 February 1999. Fire evacuation drills take place every six months, with the last fire drill occurring on 27 November 2018. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities (two BBQs, portable gas cooker and gas hobs in the kitchen) for cooking in the event of a power failure.</p> <p>There is a battery backup system in place for emergency lighting. Emergency supplies are available in all units (wheelie bins) and are checked annually. The emergency supply wheelie bins also include resident care plan information and name bands. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets, torches and batteries are available. There is sufficient water stored (water tank and bottled water) to ensure for three litres per resident for seven days. There are call bells in the residents' rooms, and lounge/dining room areas. The facility is secured at night. The service utilises security cameras in hallways.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is an outdoor smoking area where one smoker is supervised. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The infection control officer role is shared by three RN's. There is a job description for the infection control (IC) officer and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The committee and the governing body are responsible for the development of the infection control programme and its review. The IC programme is reviewed annually at head office. Annual quality and infection control goals are set at the beginning of the year. There are quarterly infection control meetings that combine with the health and safety meetings. Monthly reports are provided for quality and staff meetings which all include a discussion of infection control matters.</p> <p>The facility has developed links with the GPs, local laboratory and the infection control and public</p>

		<p>health departments at the local DHB.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme. Each of the three-infection control (IC) officers have completed external infection control education. The infection control team is representative of the facility. They meet to discuss infection rates, education and internal audit outcomes. The facility also has access to an infection control nurse specialist, public health, Bug Control, GPs and expertise within the Bupa organisation.</p> <p>Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or have been in contact with infectious diseases.</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>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control officers supported by the clinical manager who have all completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to visitors that is appropriate to their needs and this was documented in medical records. Education around infection</p>

		prevention and control has been provided.
<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>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officers use the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infections are included on a monthly register and a monthly report is completed by the clinical manager with input from the infection control officers. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly. Meeting minutes are made available to staff.</p> <p>Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Infection control data is collated monthly and discussed at the staff meetings. The infection control programme is linked with the quality management programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a regional restraint group at an organisation level, which reviews restraint practices. The Quality Committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</p> <p>There are nineteen residents in the psychogeriatric unit requiring the use of a restraint and there are no residents requiring the use of an enabler. Restraints in use include six bedrails and thirteen with a lapbelt.</p> <p>All restraint use is recorded on a restraint register. Files for five residents with restraint were reviewed. Assessments, consents and monitoring is documented. All files evidence that a documented one to two-monthly review of restraint has been conducted. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, regional restraint meetings and at an organisational level. The service implemented a quality improvement plan to reduce restraint by 10% for 2018 (link 2.5).</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for</p>	FA	<p>A registered nurse is the restraint coordinator. The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions include the restraint coordinator, clinical manager, RNs, medical practitioner and resident or family representative.</p>

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.		Restraint use and review is conducted at monthly restraint meetings and reported to the quality team meeting.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, clinical manager, RNs, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Assessments and consent forms are fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated, justified and approval processes are followed. There is an assessment form/process that has been documented for all restraint files reviewed. The restraint coordinator was interviewed. The five files reviewed have a completed assessment form and a care plan that reflects risk. Monitoring forms are present in the files reviewed. Bed rail covers are provided. Consent forms detailing the reason and type of restraint are completed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has a documented evaluation of restraint every three months. In the five restraint files reviewed, evaluations have been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at restraint meetings, quality and staff meetings. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed one to two-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator and/or clinical manager. The restraint coordinator's monthly reports evidence reporting at the restraint meetings and RN/clinical meetings. Restraint use is also reviewed as part of the quality meeting. The service is active in minimising restraint. In December 2017, there were 32 residents using restraint in the form of 21 lap belts and 11 bedrails. The service implemented a

		quality improvement plan to reduce restraint by 10% for 2018. Rossendale is commended in achieving an overall reduction from December 2017 to December 2018 of 40%.
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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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	An annual education and training schedule has been completed for 2018 and is in place for 2019. A total of 78% of caregivers have attained a national certificate qualification. There are 72 caregivers that work in the PG and dementia units and 56 have completed the required dementia standards. However, there was no documentation to reflect that five caregivers who have been employed over 18-months had completed dementia standards training. Advised that they have completed the standards but no certificates had been provided to evidence this.	There was no documentation to reflect that five caregivers who have been employed over 18-months had completed dementia standards training.	<p>Ensure that documentation reflects that all caregivers that work in the PG and dementia units have completed the required dementia standards.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings,</p>	PA Low	Hot water temperatures are taken regularly in random rooms in each wing. Not all temperatures have been documented at below 45 degrees. A corrective action plan was documented on the day which included a	Over the previous three months, several recordings in different	Ensure all hot water temperatures in

<p>plant, and equipment comply with legislation.</p>		<p>check of all individual resident room temperatures.</p>	<p>areas have been documented between 45 and 55 degrees. The service contacted a plumber to address on the day of audit.</p>	<p>resident areas are maintained below 45 degrees.</p> <p>90 days</p>
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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 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p>	CI	<p>The service is active in minimising restraint. In December 2017, there were 32 residents using restraint in the form of 21 lap belts and 11 bedrails. By the end of 2018, the service had been successful in reducing restraint to 12 lap belts and 6</p>	<p>The service implemented a quality improvement plan in February 2018 to reduce restraint by 10% for 2018 and to continuously reduce the use of restraint at Rossendale. The plan to achieve this involved three actions. Staff education, trialling residents without restraint and review of all incidents that may have been caused by restraint. Further to this plan, a corrective action plan was implemented in August following a complaint.</p> <p>All restraint use on new admissions was discontinued and a short-term care plan developed to ensure the residents safety during the trial. Meetings were held with all qualified staff to review assessment and behaviour management strategies for residents presenting with challenging behaviour. As a result, current residents using restraint were identified as suitable for a trail without either their lap belt or bed rail. Restraint education incorporating behaviour management in-services were scheduled monthly and continued until all care staff and registered nurses had attended. Meetings were held with individual families to</p>

<p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>bed rails and achieving an overall reduction of over 40%.</p>	<p>advise the risks of restraint and discuss options and proposed trails of reducing restraint. Interviews with clinical staff identified that restraint was used as a last resort and all staff worked together to identify and reduce possible reasons for the behaviours. A number of RN's discussed specific instances where identification of the cause of the behaviour was established. Interventions were implemented, and restraint was no longer required.</p> <p>By the end of 2018, the service had been successful in reducing restraint to 12 lap belts and 6 bed rails and achieving an overall reduction of over 40%.</p>
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End of the report.