# Bupa Care Services NZ Limited - BeachHaven Hospital

## Introduction

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

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

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

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

The specifics of this audit included:

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

**Premises audited:** BeachHaven Hospital

**Services audited:** Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Residential disability services - Physical

**Dates of audit:** Start date: 16 April 2019 End date: 17 April 2019

**Proposed changes to current services (if any):** The service also certified for hospital – geriatric care which has not been listed above. This was certified at this audit.

The service is also certified to provide residential disability services – physical and intellectual level care which the service request removal from their current certificate.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 89

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

BeachHaven is part of the Bupa group. The service is certified to provide psychogeriatric and hospital level care. The service has 99 beds, and on the day of audit there were 89 residents.

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

The care home manager has been in the role since June 2018. She was clinical manager previously at BeachHaven for over 20 years. The manager is supported by a clinical manager.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to BeachHaven. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

Two continued improvement ratings have been awarded around quality initiatives and infection control surveillance.

## Consumer rights

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

BeachHaven 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. Care plans accommodate the choices of residents and/or their family/whānau. There is a Māori Health Plan supporting practice. Cultural assessment is undertaken on admission and during the review process. 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

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

The care home manager is a very experienced elderly care manager. She is supported by a clinical manager, registered nurses, caregivers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Family meetings are held, and families complete an annual satisfaction survey. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. An education and training programme are established with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate cover for the effective delivery of care and support.

## Continuum of service delivery

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

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Sufficient information is gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are personalised, and goal orientated. Care plans are reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals and baking are cooked on site. This includes consideration of any particular dietary preferences or needs. There is a four-week rotational menu that is reviewed by a dietitian. Nutritional snacks are available 24 hours.

## Safe and appropriate environment

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

The building has a current warrant of fitness. 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.

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 in each unit within the facility, and also smaller lounges available 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 the 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

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. There are currently no residents with enablers. There is a restraint register in each unit. Three residents with restraint (including hand holding) were reviewed. All files evidenced that a documented three-monthly review of restraint has been completed. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level. Staff are trained in restraint minimisation and restraint competencies are completed annually.

## Infection prevention and control

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

BeachHaven has an infection control programme that complies with current best practice. The infection control manual outlines a 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. There is a dedicated infection control nurse who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level.

The infection control programme is designed to link to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Records of all infections are kept and provided to head office for benchmarking.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 99 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Bupa policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents have been provided with information on admission which includes the Code. Interviews with care staff (six caregivers, five registered nurses (RN), and three activity therapists) reflected their understanding of the key principles of the Code. Staff receive training about the Code which was last completed in April 2019 and competencies are completed annually.  Three hospital residents and six relatives (six psychogeriatric) interviewed confirmed staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident on all resident files reviewed. There was evidence of general practitioner (GP) completed and signed clinically not indicated resuscitation status. Family discussions were evident in the whānau contact form and progress notes. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Signed admission agreements, enduring power of attorney and activation documentation was evident in the resident files sampled. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | 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/whānau/EPOA and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents 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.  Family members receive the monthly activity plan and regularly join in. Physiotherapy walk groups to places of interest such as Viaduct, Devonport and walking tracks. There are weekly visits a new mother with her baby for residents to hold and enjoy. This year the service is focusing on introducing ‘the Bupa Care journey’ and encouraging more community involvement. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using an online complaints’ register. There were six complaints on the complaints log for 2018 and two, year to date for 2019. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (four rest home and three hospital) and family members advised that they are aware of the complaint’s procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes. One complaint has been via the DHB and HDC. This complaint is in the process of investigation by the Bupa quality services improvement team. The service has also undertaken an investigation and additional staff training, monitoring of residents has been implemented.  Families interviewed stated that complaints are followed up and the manager is very approachable. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | 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 in the foyer. 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 regular resident and family meetings. Relatives and residents interviewed reported that the residents’ rights are being upheld by the service. Large print posters of the Code and advocacy information are displayed in the facility. The families and residents have been informed of the scope of services and any liability for payment for items not included in the scope. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Nine resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and then integrated with the residents' care plan. There was evidence of family involvement. 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. Spiritual needs are identified, and church services are held.  A tour of the facility confirmed there is the ability to support personal privacy for residents. There is an abuse and neglect policy which is being implemented and includes staff in-service education and competencies. The 2018 family survey identified 88% confirmed the service were polite and respectful and 88% were satisfied with the quality of dementia care. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Bupa has a Māori health plan that aligns with contractual requirements. There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Bupa Māori health policy was first developed in consultation with kaumātua and is utilised throughout Bupa’s facilities. Family/whānau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. There were currently no residents that identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or the resident’s representative. Family assist to complete 'the map of life' of the resident which provides a breakdown of their life and interests/beliefs. All relatives interviewed 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. There are a number of residents from different nationalities including (but not limited to); Pacifica, Dutch, Indian and Portuguese. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The Code of Conduct is included in the employee pack. Job descriptions include responsibilities of the position and are in files reviewed. There are implemented policies to guide staff practice in respect of gifts. Clinical meetings include discussion on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the clinical manager, three registered nurses and three-unit coordinators confirmed an understanding of professional boundaries. 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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | 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.  At the beginning of each year the Quality committee hold a planning meeting & review the last year. New goals set are often to overcome any shortfalls, actions are planned and evaluated throughout the year, always the objective is to move BHH to a better place by the end of the year. All departments and units participate with hospital, unit and personal goals dovetailing. Resident Satisfaction surveys in 2017 & 2018 have both scored high.  BeachHaven continues to encourage staff to join committees or focus groups, currently all committees have staff representation. All nursing staff complete careerforce, all caregivers complete level 1 during orientation. There are three assessors on staff. All qualified staff encouraged to do PDRP, currently 27% hold one. There are Weekly visits from Community MHSOA & monthly review meetings. The service is supported by the Bupa dementia care specialist.  Their Household Department driven by the household manager has developed an initiative to welcome all families to the facility. This includes an orientation to the laundry and the kitchen. All clothing is checked for naming and family are invited to a free meal. The results of this welcoming mean that missing clothing has reduced dramatically, and families welcome the chance to taste the facilities food and have input to the menu that their loved one’s share. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident’s file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed identified that family are kept informed. Relatives interviewed stated that they are kept informed when their family member’s health status changes.  There are a number of residents (and staff) from a variety of cultures and staff interviewed were able to describe how they 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.  Family/EPOA are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print.  The service has developed a pamphlet to give new family members that contains all they need to know about the service, key people and where everything is. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa BeachHaven is certified to provide; psychogeriatric, hospital (medical and geriatric); and residential disability services - physical and intellectual level care for up to 99 residents. The service requests to drop residential disability services - Intellectual and physical from their current certificate.  On the day of audit there were 22 hospital level residents, including one funded through the Long-Term Support - Chronic Health Conditions (LTS-CHC) and one funded through ACC.  There were 67 residents including one funded through LTS-CHC and one funded through ACC across three psychogeriatric units. There were no residents funded through the younger persons disabled contracts.  The service is managed by a care home manager who is a registered nurse and has been in the role since June 2018. The care home manager was the clinical manager at BeachHaven for 20 years prior to the managers role. The clinical manager has been in the role since August 2018. He was a unit coordinator at the service prior to this role. The care home manager and clinical manager are supported by a Bupa regional manager and Bupa Clinical Service Improvement (CSI) team. The managers have completed at least eight hours of professional development.  A vision, mission statement and objectives are in place. Progress towards the achievement of annual goals for the facility have been reviewed by the care home manager. The annual goals for 2019 have been developed and communicated to staff. Discussion with the manager and review of the quality programme document a focus on community involvement, improving resident and family service information, and the development of a customer focus group. Staff training has continued to be a focus and robust follow-up of incidents and accidents. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the care home manager, the clinical manager is in charge. For extended absences, a Bupa relieving care home manager is rostered. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Bupa BeachHaven continues to implement its comprehensive quality and risk programme. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff interviewed confirmed they are made aware of any new/reviewed policies.  A range of meetings have been held, these include two monthly staff meetings, two monthly quality meetings, resident meetings and customer focus meetings, health and safety meetings including infection control, two weekly clinical forums and three-monthly RN meetings. Meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. All meeting minutes are posted in the staff room for staff to read.  Staff interviewed stated they are well informed and receive quality and risk management information such as a monthly adverse event summary.  The service collates accident/incident and infection control data. Monthly comparisons include trend analysis and graphs. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. The annual satisfaction survey 2018 has been followed up with some quality initiatives, such as improved training and upskilling for staff, improved weekend supervision, review and changes to the activities plan.  There is an implemented health and safety and risk management system in place including policies to guide practice. The care home manager with the maintenance team is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.  Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service collects incident and accident data on forms and enters them into an electronic register (Riskman). The system provides reports monthly, and the clinical manager reviews all incidents each month and writes a report for each of the units. Corrective action plans (CAP) are documented for adverse trends. An example was high falls for January; there is a report and corrective action plan documented. The report and CAP for January were documented as followed up and signed off as were reports for February and March. Each unit maintains a folder of the monthly reports for staff to read. All incidents and accidents are trended and benchmarked. Behaviour, falls and skin tears all have remained lower than other Bupa facilities with similar levels of care.  Eight falls-related incident forms and four behaviour-related incident forms were reviewed for March 2019. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The behaviour-related incident forms were residents pushing another resident. Both residents had an incident form, and both sets of family were documented as informed. All incident forms document comprehensive review and follow up.  The caregivers interviewed could discuss the incident reporting process. Staff related incident forms are discussed at the health and safety meeting.  The care home manager interviewed could describe situations that would require reporting to relevant authorities. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Ten staff files were reviewed (three RNs, four caregivers, the clinical manager, an activity staff member and a cook). All files contained relevant employment documentation including current 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 psychogeriatric and hospital level care. Staff interviewed believed new staff are adequately orientated to the service on employment.  There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The service has provided extensive training for staff as well as additional tool box talks to follow up incident forms complaints, changes in resident care needs. A continuous improvement has been awarded for training related to the management of behaviours that challenge.  Ten of fourteen RNs have completed interRAI training. Clinical staff complete competencies relevant to their role including syringe driver training, medication management and pain management. The RNs also have access to external training.  There are 66 caregivers who work in the unit; 56 have completed the required dementia standards, seven are in the process and three have recently started at BeachHaven. The activity staff (three are part of the numbers who have completed the standards). |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meets contractual requirements. The care home manager is available during weekdays. The care home manager is on-call after hours with assistance from the assistant manager for non-clinical issues. Adequate RN cover is provided 24 hours a day, seven days a week. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes and meet best practice.  Caregivers interviewed stated that there is enough staff on all shifts to safely manage resident care. Staffing includes;  A care home manager and clinical manager Monday to Friday and occasional weekends, plus three RN unit coordinators who work Monday to Friday and occasional weekends. This senior clinical staff team all take turns to work weekends to ensure senior oversight at all times.  There are also administration staff, housekeepers, kitchen staff, laundry and maintenance.  Each of the units is staffed separately. Staff informed that they assist each other as needed.  Kowhai - a PG unit is divided into A and C wings. The service uses these two wings for residents with a lower level of psychogeriatric need. Each of the wings has an RN for the AM and PM shift and one RN for both overnight  Caregivers;  A wing has 19 beds with 16 residents on the day of audit. AM - two long and two short shifts. PM - one long and one short shift, night one caregiver.  C wing has 21 beds with 16 residents on the day of audit. AM - two long and one short shifts. PM - one long and two short shifts, night one caregiver.  Tui wing is divided into B and D wings. The service uses these two wings for residents with a higher level of psychogeriatric need. Each of the wings has an RN for the AM, PM and shared for the night shift.  B wing has 16 beds with 15 residents on the day of audit. D wing has 16 beds with 16 residents on the day of audit. Staffing is shared; AM - four long and two short shifts, PM - two long and two short shifts, night one caregiver plus an additional RN is shared between the two wings.  East wing (hospital level care) has 27 beds with 22 residents on the day of audit. There is at least one RN each shift plus the unit coordinator on the morning.  Caregivers;  AM - three long and three short shifts, PM - two long and one short shift, there is also an ACC funded additional caregiver for the AM and PM shift. There is one caregiver on nights. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are stored on the electronic medication management system. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. Information gathered at admission is retained in resident’s records. Relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the manager. The service has a well-developed information pack available for residents/families/whānau at entry including admission to PG unit. An advocate is available and offered to family. The admission agreement reviewed ARC and ARHSS contract. The ten admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. Residents who require admission to hospital or transfer are managed appropriately and relevant information is communicated to the receiving health provider or service. A transfer form and supporting documentation accompanies residents to the receiving facility and communication with family is documented. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There are two medication rooms on site, both have secured key pad access. Medication fridges had daily temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored. Registered nurses or senior caregivers who have passed their competency, administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GPs.  The facility utilises an electronic medication management system. Twenty medication profiles were sampled (fourteen psychogeriatric and six hospital care). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of PRN medication administered were documented in the electronic prescription. Controlled drugs and registers align with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The housekeeper services manager oversees the procurement of the food and management of the kitchen. The service is supported by one full time chef and one relieving cook. All food services staff have attended food safety training. The main chef is also a trained assessor. There are food service manuals and a range of policies and procedures in place to guide staff. There is a well-equipped clean kitchen and all meals are cooked on site. The main kitchen is connected to one of the PG units (Kowhai). There is a servery into Kowhai unit. There is a separate dining room in each area and kitchenette. Meals are delivered to two psychogeriatric units (Tui) and the hospital unit (East wing) in a bain marie and plated in the unit. On the day audit meals were observed to be hot and well presented. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and documented daily; these were within safe limits.  The residents have a nutritional profile developed on admission which identifies dietary requirements, 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 by the registered nurse or unit coordinator. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff. The national menus have been audited and approved by an external dietitian. There was evidence that there are additional nutritious snacks available over 24 hours.  Facility meetings and surveys provide feedback on the meals and food service. Residents and families interviewed were very happy with meals provided and confirmed that alternative food choices were offered for dislikes. The service has a current food control plan displayed. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. 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 for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Bupa assessment booklets and LTCPs reviewed were comprehensively completed for all ten resident files reviewed. The assessment booklet provides in-depth assessment across all domains of care. For the ten resident files sampled, interRAI assessments and risk assessments were implemented and reflected into the care plans. Risk assessments are completed on admission and reviewed six monthly or when there is a change in residents’ condition. Additional assessments for management of behaviour, wound care and restraint were appropriately completed as required. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed were comprehensive and demonstrated service integration and demonstrated input from allied health. The interRAI assessment process informs the development of the residents’ care plan. All ten resident care plans were resident centred and documented in detail their support needs. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Whānau communication and meetings were evidenced in the documentation reviewed. Long-term care plans in the psychogeriatric unit (PG) detail care and support for behaviours that challenge, including triggers, associated risks and management. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. Staff interviewed reported they found the care plans easy to follow. There was evidence of service integration with documented input from a range of specialist care professionals. Psychogeriatrician and mental health team support and advice was evidenced and documented. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and caregivers follow the care plan and report progress at each shift handover. All care plans reviewed included documentation that meets the need of the residents and had been updated as residents` needs changed. If external allied health requests or referrals are required, the unit coordinator’s initiate the referral (eg, wound care specialist, dietitian, or mental health team). The GP interviewed on day of audit spoke highly of the service and confirmed of being kept informed of changes in resident condition. Family members agreed that the clinical care is good and that they are involved in the care planning.  Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. Wound management, monitoring and reviewing occurred as planned in the sampled files reviewed. All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Care plans document allied health input.  Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents. Care plan interventions clearly demonstrate that residents’ needs are met. There was evidence of two hourly turning charts, monthly weight and vital sign monitoring, food and fluid charts and daily activity check lists. The service has commenced the HEHP (high energy high protein) weight management plan for residents with weight loss and this has improved outcomes for residents with weight loss. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one diversional therapist (works 30 hours Monday through Thursday) and two activities assistants (works 35 hours Monday to Friday) that coordinate and implement the programme for each unit. The service has employed a new activities assistant that will be working over weekends to oversee the activities programme. The service has a contracted physiotherapist and assistant that assists with the exercise, mobility and walking programme. The diversional therapist and activities coordinators have received training around dementia care and needs. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The Bupa activities programme template is designed for high-end and low-end cognitive functions and meets individual cognitive, intellectual and physical needs. Activities include (but not limited to) arts, crafts, music, exercises and board games. Community links are maintained with visiting church groups, outings to places of interest and picnics. The residents were observed engaging with the pet therapy dog on the day of the audit. The programme is developed monthly and displayed in large print in all units and communal areas. Residents have an assessment and MOL (map of life) completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family etc. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly as part of the care plan review. The residents' activity care plans have de-escalating techniques for residents with behaviour that might challenge.  The service receives feedback and suggestions for the programme through surveys, monthly facility meetings and resident meetings. Family members interviewed spoke positively about the activities programme and team members. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The files reviewed demonstrated that all interRAI assessments and care plans reviewed were evaluated at least six monthly or when changes to care occurs. Where the enrolled nurse reviews care plans it is counter-signed by the registered nurse. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. All changes in health status are documented and followed up. The multidisciplinary review involves the RN, GP, activities staff resident/family, unit coordinator and clinical manager. The files reviewed reflect evidence of family being involved in the planning of care and reviews. In all the files sampled care plans have been read and signed by EPOA/family. There is at least a three-monthly review by the medical practitioner with majority of residents being seen monthly. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referral through the unit coordinators and specialist referrals are made through the GP. There was evidence of where a resident’s condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies related to chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. There is a secure sluice room in each area. All chemicals sighted were clearly labelled with manufacturer’s labels and stored in locked areas in all services. Safety datasheets and product sheets are available. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The maintenance person interviewed described the safe management of hazardous material. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness which expires on 26 April 2019. Fire equipment is checked by an external provider. The maintenance person interviewed described the reactive and preventative maintenance occurs. There is a 52-week planned maintenance programme in place. Electrical equipment has been tested and tagged. Hot water temperature is monitored weekly in resident areas and at hot water cylinders.  There are three specific communities (Tui community is PG level and divided into two separate 16-bed units: one male only and one female only). Kowhai community is PG level care and East wing community is hospital level.  In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. There are quiet, low stimulus areas that provide privacy when required.  There have been a number of environmental improvements made since previous audit. There has been refurbishment of resident rooms in Kowhai unit including a family/whānau room, upgrades to outdoor decks, unit décor. The living areas and bedrooms have vinyl surfaces as do communal bathrooms/toilets and kitchen areas.  The corridors are wide enough around the facility and handrails available to promote safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are areas to wander inside and outside with secure garden areas off both PG units. The service currently has an outdoor maintenance project being undertaken where asbestos is being removed by contractors from spouting and roofs. All working hazardous areas are closed off to residents and staff.  There is sufficient equipment available to staff in all areas that is calibrated.  There are outdoor areas with seating and shade. There is wheelchair access to all areas. The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.  A previous project of planting fruit trees in the hospital grounds is now bearing fruit, providing apples, peaches, grapes, limes, mandarins and plums. These are shared amongst residents and staff. The decks of the refurbished Kowhai unit have all had new pots. Planting and outside furniture coordinating with the unit décor, even providing a small vegetable garden for one resident who misses his own. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate toilets and showers in the East hospital community (unit) and two PG unit. Resident rooms in the hospital have hand basins with a mix of ensuite facilities and communal bathrooms. The PG communities all have communal bathrooms that are well signed. All communal bathrooms allow for mobility equipment. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Communal toilets and bathrooms have appropriate signage and locks on the doors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Residents' rooms in the hospital and PG wing are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. There are a number of double rooms in the PG unit and all include curtains for privacy. Mobility aids can be managed in ensuite and communal bathrooms. Residents requiring transportation between rooms or services are able to be moved safely from one area to another. Staff interviewed reported that they have adequate space to provide cares to residents. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Activities occur throughout the facility and in the lounge areas. The open plan lounge areas are spacious and can be used for activities and small groups as well as for private social interaction. The upgraded resident/whānau room provides a quiet area in the larger Kowhai unit. The large kowhai lounge has been refurbished and designed to allow for small and larger group activities. Activities are to occur in any of the lounges and they are all large enough to not impact on other residents not involved in activities. Seating and space is arranged to allow both individual and group activities to occur. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The two Tui units (16-bed male unit and 16-bed female unit), there are separate lounges that can be opened up as one or closed off. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is completed on site. There is a well organised laundry situated off the hallways between the PG unit and the hospital unit. Laundry is transported from each area in closed line trolleys. There is only one door for entrance and exit and the two-laundry staff interviewed could describe how they maintain a “dirty” to “clean” flow. There are appropriate systems for managing infectious laundry, which laundry staff could describe. There is a comprehensive laundry manual; cleaning and laundry services are monitored throughout the internal auditing system and the resident satisfaction surveys. The cleaner’s trolleys were attended at all time or locked away in the cleaning rooms as sighted on the day of the audit. There is a sluice room in each part of the facility for the disposal of soiled water or waste. Personal protective equipment is available in the laundry. Relatives and residents interviewed were happy with the laundry and cleaning services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There was a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs were in place. There has been a complete upgrade of the smoke detector system since the previous audit. All secure doors are connected to the fire alarms. The service has alternative gas facilities for cooking in the event of a power failure with a backup system for emergency lighting and battery backup. A power outage last year resulted in the service completing a section 31 notification. Oxygen cylinders are available. There is a civil defence kit in the facility and stored water including an emergency water tank. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has plenty of natural light. There is overhead heating in the corridors and resident rooms and panel heaters in the main areas. The facility and grounds are a smoke free area. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The Bupa infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and infection control programme description is available. The infection control officer is an RN. There is a job description for the infection control (IC) officer and clearly defined guidelines. The infection control programme is linked into the quality management programme. The Infection Control committee meets as part of the health and safety meetings. The quality meetings reviewed also include a discussion of infection control matters. The IC programme is reviewed annually through the Bupa North Island IC group and head office. Annual quality and infection control goals are set at the beginning of the year and document in-depth review. The facility has developed links with the GPs, local laboratory and the infection control and public health departments. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme. The infection control (IC) officer has 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, GPs and expertise within the organisation.  Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control officer supported by the clinical manager who have both completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Additional training has been provided around UTI care and the use of Bupa infection criteria prior to logging and infection. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and laboratory that advise and provide feedback/information to the service.  Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register. The service has been awarded a continuous improvement around the reduction of UTIs.  A norovirus outbreak, December 2018 was managed well. The public health department were informed and a section 31 was reported. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 is restraint is and what is an enabler. The restraint policy includes comprehensive restraint procedures.  There are currently no residents with enablers. There is a restraint register in each unit. In East wing (hospital) there are two bedrails. In Kowhai unit there is one bedrail, three low beds, and three T belts for intermittent use. Four residents on the register have also been identified as requiring intermittent hand-holding during personal cares.  Across Tui units, there is one low bed, two bedrails, one lap belt and seven residents on the register that have also been identified as requiring intermittent hand-holding during personal cares.  Three residents with restraint (including hand holding) were reviewed. All files evidenced that a documented three-monthly review of restraint has been conducted. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is the care home manager (registered nurse). The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions included the restraint coordinator, clinical manager, registered nurses, resident/or family representative and medical practitioner. Restraint use and review, is part of the monthly restraint meeting and quality team meeting. A review of restraint meetings identifies regular review of each restraint use and regular removal of restraints where it was identified as not required. |
| 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. Assessments and approvals for restraint were fully completed (including hand holding). These were sighted in the three files reviewed. BeachHaven restraint committee determined that any form of hand holding was also a restraint. Care plans reviewed clearly described the process around distracting the resident, and gaining consent from the resident to hold their hand. While hand holding was only used intermittently during personal cares to avoid injury to staff, staff clearly described releasing the hand-grip if a resident pulled away or did not like it. There were clear guidelines around the practice of hand holding as a de-escalation technique; however, BeachHaven have documented all episodes of hand holding and is managing as a form of restraint to manage their risk. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are followed. The three restraint files reviewed had a completed assessment form and a care plan that reflected risk and interventions to manage the risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. The service had a restraint register in each unit which has been updated each month. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. There is also a monthly review of each restraint at the restraint committee meeting and six-monthly review with family as part of the MDT meeting. In the three restraint files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Evaluation timeframes were determined by risk levels. Any restraint incidents are reported through RiskMan and discussed at the restraint committee meeting. Two incidents reviewed by the committee in January 2019 included a resident who tried to climb over the bedrail. The review identified removing the bedrail and changing to a low bed. Another incident of emergency restraint was used for a resident for safety, following a seizure. Staff were informed of changes and care plans updated to reflect the change of restraint. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews were completed monthly and three monthly. Reviews were completed by the restraint coordinator and/or clinical manager. Any adverse outcomes were included in the restraint coordinator’s monthly reports and were reported at the monthly meetings. Restraint use is reviewed as part of the quality team meeting. There is an organisation restraint committee. Benchmarking is completed of all restraint use across Bupa and BeachHaven has been identified as the 4th lowest (of nine PG units) for restraint use. |

# Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Since the previous audit the service reviewed incidents and accidents, and noted that 84% of all incidents were related to behaviour issues. The service decided to work toward reducing behavioural incidents for residents. It was considered an important project as the service were increasing the amount of psychogeriatric beds and to ensure staff and resident safety. | The service decided to work toward reducing behavioural incidents for residents. The service initiated a series of interventions with staff. This included increased training around behaviour management, focusing on resident centred care and a move away of the traditional task orientation. Small group discussions were initiated, one-on-one mentoring put in place and education around correct documentation for behaviour monitoring and associated tools. Alongside the training and support, considerable importance was placed around documenting the Map of Life for residents with forums to discuss each resident and their needs. Results over 2018 documented that there has been a significant reduction in resident behavioural incidents month on month, despite an increase in the number of residents. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | A quality initiative was to reduce infections through education, create an embedded culture of high infection control standards and correct reporting of infections. | The infection control officer (clinical manager) presented a range of education sessions around infection control and additional tool box talks to ensure a wide coverage of staff. The clinical manager analysed infection control every month and followed up on infections and the resident’s care plan. Corrective action plans were documented each month when infections were high, or infection control logs had been incorrectly documented. This has resulted in a continued downward trend for urinary tract infections and wound infections over time. The total UTIs for January 2018 were five and two for December 2018, 2019 UTIs have remained low, at one for the last three months. The combined projects of behaviour management, UTI prevention and raising the standard of infection control and documentation have shown very positive results. |

End of the report.