

Bethesda Care Limited - Bethesda Care

Introduction

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

The audit has been conducted by The DAA Group 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:	Bethesda Care Limited
Premises audited:	Bethesda Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 January 2020 End date: 29 January 2020
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:	51

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bethesda Care Limited - Bethesda Care, provides care for up to 72 residents requiring rest home or hospital level care.

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

There was one area identified as requiring improvement at the last audit related to the timeliness of interRAI assessments. This has been addressed. At this audit there were eleven areas identified as requiring improvement. These related to complaints management, documenting strategic goals, measuring achievement against the quality and risk programme, analysing quality and risk data, corrective action planning, incident/accidents, maintaining staff orientation records, documenting a training plan and conducting staff performance appraisals, documenting a staffing rationale, aspects of medicine management and analysing and communicating resident infection data.

Residents and family members interviewed were satisfied with the staff and management team, as well as the services they provide.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Open communication between staff, residents and families is promoted and was confirmed to be effective.

The complaints related policy details the process to report, acknowledge, investigate and respond to complaints. Residents and family members confirmed the current management team have responded to any concern or complaints in a timely manner.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The organisation's philosophy, aims, values and quality objectives are documented. Since the last audit there have been changes in the management team with a new chief executive, facility manager and clinical manager being appointed as well as the recent establishment and appointment of two unit coordinators; both are registered nurses.

The quality management systems included incident/accident reporting, risk management, resident and staff satisfaction surveys, restraint minimisation, monitoring enabler use, and infection control data collection. Appropriate policies and procedures are available for staff reference.

New staff are provided with an orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that they are satisfied with the staff and care provided. There is always at least two registered health professionals on duty, comprising either two registered nurses, or a registered nurse and an enrolled nurse, and at least three health care assistants.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are stored securely. An electronic medicine management system is in use.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Bethesda Care had a current building warrant of fitness. There have been no changes to the building since the last audit. There have been no changes required to the approved fire evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint minimisation and safe use policy and associated procedures includes definitions that comply with the standard. Staff are provided with training on restraints and enablers during orientation and the ongoing staff training/competency assessment programme. There was one resident with a restraint in use at the time of audit. There were no residents using enablers.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed when needed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	8	0	4	4	0	0
Criteria	0	28	0	7	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Moderate	<p>Bethesda Care has a complaints management policy readily available to ensure complaints processes reflect a fair complaints system that complies with the Code of Health and Disability Services Consumers' Rights (the Code). During interview, residents, family members, and staff reported their understanding of the complaints process and this aligns with the policy. Template forms and a drop box are available at the main entrance so residents and family members can provide feedback or make a complaint at any time.</p> <p>A complaints register is maintained by the Bethesda Care facility manager, who is responsible for the complaint's management process. However, this does not include details of all complaints and the actions taken. This is an area requiring improvement.</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The family members interviewed confirmed that they were kept informed of their relative's wellbeing including any incidents, accidents, changes in wellbeing and medications affecting their relative and were happy with the timeframes that this occurred.</p> <p>Communications with residents and family members were documented in sampled</p>

		<p>residents' files.</p> <p>All except one resident can effectively communicate in English. A list of key phrases in the resident's first language and English is displayed on the wall in the resident's bedroom. Staff interviewed confirmed they can effectively communicate with this resident about day to day care. There are several other residents who have English as a second language. Staff are aware of how to access interpreter services should this be required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Low	<p>Since the last audit there has been significant changes in the management team at Bethesda Care. This includes new members of the board, a new chief executive (commenced August 2019), a new facility manager (commenced May 2019) and a new clinical manager (commenced 6 January 2020). An interim clinical manager was in the role for three months commencing 1 October 2019 and continues in a consultancy / project management role. Two new unit coordinator (registered nurses) roles have been established and recruited with one starting in December 2019 and one starting on 6 January 2020. Job descriptions have been developed for all these positions detailing roles and responsibilities. The management team noted that with the newness of some of the roles, and that some staff are still completing their orientation, they are still working to imbed all components of the roles into practice. These changes are intended to strengthen clinical governance and the oversight of residents' care.</p> <p>The quality assurance and risk management policy details the organisation's quality related goals/objectives. The scope, mission and values of Bethesda Care are also documented. The Bethesda care executive board is yet to develop a business or strategic plan. This is an area requiring improvement.</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>	PA Moderate	<p>The organisation has a quality and risk management system which includes having current policies and procedures available for staff. Policies and procedures have been developed by an external consultant. The external consultant reviewed key policies and procedures with designated members of the management team and have localised most of them to reflect the needs of Bethesda Care. Work is ongoing with the assistance of a member of the CMDHB infection prevention and control team to ensure the infection prevention and control policies reflect current local practice. Communications related to this process were sighted. The policies and procedures</p>

		<p>are readily available to the registered nurses and enrolled nurses electronically. One paper copy of all policies and procedures is held in the facility manager's office. Health care assistants and other staff are able to obtain any policy/procedure information by requesting the facility manager or any one of the registered/enrolled nurses on duty. Requested policy documents were easily located when using the electronic search function.</p> <p>The quality and risk programme includes complaints/compliments processes, hazard identification / management, incident/adverse event reporting, internal audits, undertaking satisfaction surveys, restraint minimisation and reporting residents with infections. Health care assistants interviewed could detail their responsibilities for reporting concerns, complaints and accidents/incidents. The chief executive is actively monitoring and reporting on business/operational risks as a component of the formal reports to the board and this process was sighted. Individual resident's clinical risk is monitored via the interRAI assessment and care planning process.</p> <p>While quality and risk issues are discussed at various meetings, minutes are not consistently maintained of these meetings or do not include all discussions, including analysis and discussion on the themes and trends of some types of incidents/adverse events. Internal audits are not consistently occurring, or records of some completed audits could not be located, and some quality and risk activities are not being effectively linked to the wider quality and risk programme. A process that demonstrates monitoring of the key performance indicators was not able to be reviewed. The hazard register is overdue for review. While there were some examples of appropriate corrective action plans being developed, implemented and monitored, this was not consistent. These are areas requiring improvement.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>Staff document adverse and near miss events on an electronic accident/incident form. The requirements and associated processes are guided by the adverse event management policy (September 2019). Improvements are required in the process of recording actions taken and linking the incident management system with information recorded (investigations, actions taken and evaluations) that are documented in residents' clinical record as these are completely separate records/programmes, as well as closing events when the required actions have been implemented and verified as being effective.</p> <p>The facility manager and clinical manager described the essential notification reporting requirements, including for pressure injuries, outbreaks of infection and</p>

		<p>registered nurse recruitment difficulties. They advised there had been essential notifications made about the changes in clinical manager. The most recent notification was made by the chief executive during audit. No other events have required notification. The management team advised they are not aware of any police investigations or deaths resulting in a coroner's inquest since the last audit. Bethesda Care is advising the DHB portfolio manager of complaints received.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. All current employed and contracted registered health professionals have a current annual practising certificate. A sample of staff records reviewed confirmed the organisation's recruitment policies are being implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role, however records are not consistently retained to verify that staff have completed all requirements including where applicable medicine competency. Ongoing education is occurring; however, a training plan for 2020 has not yet been developed. A staff member with a current first aid certificate is not always on duty. Annual performance appraisals are not occurring.</p> <p>There are three registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. In addition, the new clinical manager has current interRAI competency and is awaiting the transfer of access rights from her prior employer to Bethesda Care.</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>	PA Low	<p>Residents and family members interviewed verified that there was sufficient staff on duty to meet their care needs. Staffing numbers are being adjusted. An acuity tool is in use, however this and the associated staffing and skill mix policy could not be located during audit. A staff member with a current first aid certificate is not on duty at all times (refer 1.2.7.5). There is always two registered nurses or a registered nurse and enrolled nurse on duty.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Records were not available to demonstrate that four RNs have completed the medicine competency assessment (refer criterion 1.2.7.5). There are processes in place to assess that residents self-administering medicines are safe to do so (refer to 1.3.3.). Residents and family members interviewed advised they are informed of any changes to medications and the rationale.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Medications are checked against the prescription.</p> <p>Controlled drugs are stored in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The stock take was last done in December 2019.</p> <p>Vaccines were not stored onsite. Standing orders were not used.</p> <p>Improvements are required in the consistency monitoring the medicine refrigerator temperature, pro re nata medicine prescribing, ensuring three monthly reviews of resident medicines are consistently documented as occurring by the general practitioner, and aspects of medicine management for residents when paper-based records are in use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided onsite by one qualified chef, supported by five further cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter menu patterns and was reviewed by a qualified dietician in August 2017. Recommendations made at that time have been implemented.</p> <p>The service has implemented the food control plan certified by Ministry of Primary Industries. The food safety audit was conducted by Auckland Council in October 2019 and there were no findings. Food temperatures, including for high risk items, are monitored appropriately and recorded. All cooks have undertaken a safe food handling qualification.</p> <p>A nutritional assessment was undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences including cultural aspects, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p>

		Evidence of residents' satisfaction with meals was verified by resident and family interviews. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
<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>Documentations, observations and interviews verified that the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individual needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered according to instructions.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment including a bariatric bed, air mattress and other resources were available in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by one trained diversional therapist holding the National Certificate in Diversional Therapy and an activities assistant.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interest, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the residents' meetings and care plan review process. Activities planners were sighted in residents' room and residents' interviewed confirmed that they are actively involved in activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment, or as residents' needs change. Where progress is</p>

		different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and pressure injury care. When necessary, and for unresolved problems, long term care plans are added to an updated. Six residents and three families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There was a current building warrant of fitness (expiry 26 September 2020). The facility manager advised there have been no changes to the approved fire evacuation plan in use at the time of the last audit.
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.	PA Low	The care staff and registered nurses were aware of the reporting process for residents who develop an infection. New infections and any required management plans were discussed during the handovers. Individual infections were reported but there was no evidence of surveillance or infection control data. There has been no outbreaks of infection since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	A policy provides guidance for staff on restraint minimisation and safe practice and the use of enablers. There were no residents with enablers in use during audit. One resident has a restraint in use. Appropriate assessments have been completed prior to restraint commencing, consent has been obtained and the use of restraint is noted in the resident's care plan. Ongoing monitoring is occurring of the resident when the restraint is in use. One of the unit coordinators is the restraint coordinator. A restraint register is being maintained. Staff are provided with education on the use of restraints and enablers during orientation, and as part of the ongoing education programme. Training most recently occurred in December 2019 in response to a reported incident/event. Staff interviewed could detail the organisation's requirements in relation to the use of restraint including that this is used as a last resort after other interventions have been considered / implemented.

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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>The complaints register is electronic from the 1 September 2019 onwards, when Bethesda Care transitioned to having an electronic complaint reporting and management process. This register included details of eight complaints. Two other complaints had been recorded as an incident although managed as a complaint.</p> <p>The complaints register did not include details of four complaints sampled. This included two complaints received via an independent advocate (dated 6 November 2019 and 9 January 2020) and two other complaints that were received. One of these complaints was received via the Health and Disability Commissioner and the other via the Accident Compensation Corporation.</p>	<p>The complaints register does not include details of all complaints received dates and actions taken.</p> <p>Records are not available to demonstrate that complaints are consistently acknowledged, investigated and responded to within timeframes that comply with the Code, although residents and family members interviewed reported there has been a recent improvement in complaints management processes and associated communication.</p>	<p>Consistently document all complaints received, dates and actions taken in the complaints register.</p> <p>Ensure records are available to verify that all complaints are consistently acknowledged, investigated and responded to within timeframes that comply with the Code.</p> <p>90 days</p>

		<p>Of the five sampled complaints, records are only available for one of these complaints to verify it was acknowledged, investigated or responded to within timeframes required by the Code. There is no documented follow-up and investigation of a complaint received in October 2019, no final communication documented with a complainant (December 2019), and no records of acknowledgment for a complaint received earlier in January 2020 although an investigation into this complaint is underway. The facility manager detailed actions that had been taken in response to each of these complaints. For the other complaint sampled, an extension of time has been requested to investigate and respond to this complaint.</p> <p>A complaint to the DHB in March 2019 was investigated. The management team have been actively working to address the improvements that were identified as being required.</p> <p>Residents and family members interviewed confirmed the current management team have been very responsive in addressing any concerns or complaints made. This included interviews with a resident and family member who had made complaints that were included in the sample reviewed during audit. The feedback from the resident and family about the complaint resolution process aligned with the information verbalised by the facility manager although not all actions had</p>		
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		been documented.		
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	<p>The chief executive (CE) was appointed to the role in August 2019; however, has been a member of the executive board, providing oversight of Bethesda Care and other organisations/entities operated by the Seventh Day Adventist Church for over seven years. The CE has a background in information technology and has held senior management roles in organisations including local government. The executive board comprises seven members, some of whom have been recently appointed. An experienced aged related residential care nurse / manager has been recently appointed (2019) in a clinical resource role to the executive board. The executive board meets at least four time per annum. The chief executive is responsible for formally reporting to the executive board about services provided at Bethesda Care. This include operational and quality/risk issues and examples of these reports were sighted.</p> <p>The quality assurance and risk management policy details the organisation's quality related goals/objectives. The scope, mission and values of Bethesda Care are also documented in other documents including staff job descriptions. The Bethesda Care executive board is yet to develop a business or strategic plan for Bethesda Care. The chief executive advised this is scheduled to be discussed</p>	<p>Current strategic direction and goals for Bethesda Care have not been documented. The chief executive advised these will be discussed at the next executive directors board meeting.</p>	<p>Document the strategic direction and associated goals for Bethesda Care and implement a process for regularly reviewing progress to achieve these.</p> <p>180 days</p>

		<p>at the next executive board meeting in March 2020.</p> <p>The clinical manager is responsible for ensuring the day to day needs of the residents are met. The clinical manager commenced working at Bethesda Care on 6 January 2020. She is an experienced registered nurse having worked in a variety of roles including senior or management roles for aged related residential care services and community-based services. The clinical manger has a 'Post Graduate Diploma in Health Sciences' (University of Auckland), has interRAI competency (is awaiting the transfer of access to Bethesda Care), and has completed more than eight hours of education related to managing an aged related residential care service in the last year as required by the provider's contract with Counties Manukau District Health Board (CMDHB). The interim clinical manager is available for ongoing advice / support.</p> <p>The service has Aged Related Residential Care (ARRC) contracts with CMDHB for hospital (continuing care) and rest home level care. This includes short term care. A contract is also held to provide care to residents with long term support-chronic health conditions (LTS-CHC). On the days of audit 51 residents were receiving services. This comprised 34 hospital level care residents and included two residents under the LTS-CHC contract (one resident was under 65 years of age). There were 17 residents receiving rest home care which</p>		
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		included one person admitted for short term care/respite. There were no borders.		
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>The quality assurance and risk management policy (September 2019) includes 23 internal audits that are to be completed as a means of assessing compliance and identifying areas requiring improvement. The results of the audits, satisfaction surveys and other quality and risk data are to be utilised to monitor the organisation's performance against 11 documented key performance objectives. There are template audit tools available for each audit. A process has not been implemented to identify when these audits/surveys will be undertaken and by whom. The previous interim clinical manager advised a range of documentation audits were completed in late 2019, and the minutes of the registered nurse meetings reflected discussion on this requirement. However, the results of these audits could not be located during audit. The interim clinical manager was unable to attend and staff including the facility manager, two administration staff and the new clinical manager could not locate the reports. Records were not available to demonstrate a monitoring process to ascertain progress towards achievement of the organisation's documented quality objectives / key performance indicators.</p> <p>A 'next of kin' survey had been undertaken in September 2019, with ten</p>	<p>The quality assurance and risk management policy details the internal audits that are to be completed. A process has not been implemented to schedule when these are to occur, who is responsible, and where records are to be located/filed.</p> <p>Some quality improvement activities have been undertaken, for example a next of kin survey, and a staff survey. However, there is no clear process to ensure the results are reviewed and communicated/ linked to the overall quality and risk programme.</p> <p>A process of monitoring progress towards the quality objectives/key performance indicators was not sighted.</p>	<p>Establish and implement an internal audit calendar/schedule that aligns with the requirements of the Bethesda Care quality assurance and risk management policy.</p> <p>Identify who is responsible for undertaking the various audits/surveys and where the resultant records are to be located. Ensure the results of audits/surveys are monitored and followed up in a timely manner.</p> <p>Implement a process to monitor progress for achieving the quality objectives / key performance indicators.</p> <p>90 days</p>

		<p>respondents. None of the management team interviewed were aware of the results. The report (dated 26 September 2019) was obtained during audit from the external quality consultant who conducted the survey. The facility manager advised a staff satisfaction survey was conducted sometime earlier in 2019. However, records were not available of the results.</p> <p>A safety and satisfaction survey of residents was conducted in February 2019 and included topics related to daily care, clinical needs, medication, the environment and personal belongings. Twenty-three residents responded to the survey. The survey report and corrective action plan was sighted.</p> <p>Audits of the timeliness of staff response to call bells has occurred and the results acted upon and communicated, with improvements noted in subsequent re-audits.</p>		
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>Incidents and infections are now being reported electronically and individual events investigated and managed. While there is a dashboard on this electronic programme that enables detailed reports to be obtained of the number and types of reported events, and the timeframes the events are reported as occurring, these reports are not being utilised to guide potential improvements in systems/processes. The number of pressure injuries and medicines errors</p>	<p>Incidents and infections are being reported electronically and individual reported events managed. There is currently no process to consistently evaluate themes and trends over time and to communicate these with applicable staff.</p> <p>Minutes are not consistently maintained or able to be located for meetings held with the health care</p>	<p>Ensure a process is implemented to evaluate the number, themes and trends of infection and adverse events/incidents.</p> <p>Implement a process to review and update the hazard register.</p> <p>Ensure meeting minutes are maintained for all meetings and consistently include</p>

		<p>have been discussed in recent registered nurse meetings; however, there is no evidence of overall evaluation of other types of events including falls. There is currently no process to consistently evaluate themes and trends over time and to communicate the findings with applicable staff. Health care assistants interviewed reported they are informed of all new resident incidents and infections as a component of the shift handover, but no longer receive information about overall numbers, themes, trends and bigger picture prevention strategies in relation to adverse events and infections.</p> <p>Meetings with health care assistants (HCA's) occur and some quality and risk topics are included in the meeting discussion. However, minutes of only one HCA meeting (December 2019) was available for review. Minutes of other HCA meetings have either not been recorded or could not be located. The facility manager reported these meetings occur approximately two monthly.</p> <p>There is a head of department / management / quality improvement meeting. The attendees include the chief executive, the facility manager, the village manager and the clinical manager. A template is available for recording minutes. The minutes of four meetings between 16 September 2019 and 13 January 2020 sighted did not consistently or regularly include discussions on accidents/incidents/adverse events,</p>	<p>assistants. While there are templates available to record the minutes for the various regular meetings held (health care assistants, registered nurses, health and safety, and head of department / management / quality improvement) meeting, the minutes sighted do not consistently reflect discussion on all relevant/applicable quality and risk issues.</p> <p>The health and safety register is dated 2016.</p>	<p>information on discussions including quality and risk issues.</p> <p>90 days</p>
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		<p>infections and health and safety.</p> <p>Minutes of four health and safety committee meetings were sighted for 2019 (April, August, October and December). The minutes note the health and safety register requires review and updating. This has not occurred yet, although the hazard register and associated documents were on the facility manager's desk on the first day of audit, as one of the tasks on the current 'to do' list. The hazard register provided for review during audit was dated 2016.</p>		
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective actions have been taken in response to incidents sampled although the actions taken are noted in residents' records and not consistently linked to the incident reporting system (refer to 1.2.4.3). The call bell audit reports sighted demonstrated that appropriate actions have been taken resulting in an improvement in timeliness of call bells being answered. Actions taken in response to complaints are not consistently documented, although the residents and family members interviewed report improved communication and actions have been taken in response to their complaint/concern (refer to 1.1.13.3). An action plan has not been undertaken in response to the resident satisfaction survey (conducted September 2019) as none of the current management team had received/sighted the report. Where follow-up actions are requested in</p>	<p>While there are some examples of timely and effective corrective action plans being developed, documented and implemented, this is not consistent for complaints, audit/satisfaction surveys and some of the issues noted in meeting minutes.</p>	<p>Ensure corrective actions plans are consistently documented when areas for improvement are identified as being requiring and include the actions required, timeframes, and person responsible. Ensure a process is implemented to monitor the effectiveness of actions undertaken.</p> <p>90 days</p>

		meeting minutes these do not consistently identify a timeframe for when the actions are to be completed within, for example, updating the hazard register has been noted as a task in meeting minutes for at least five months (refer to 1.2.3.7).		
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Staff are now reporting adverse events/incidents electronically since 1 September 2019. Prior to this a paper based reporting process was utilised. Staff have reported a range of events in the data sighted including medication errors, bruises, skin tears, lost property, pressure injury, wandering, episodes of challenging behaviour, falls and staff injuries/events. Resident related events had been investigated and followed up in a timely manner in the electronic residents' records sampled. This includes development and implementation of wound care plans, implementation of individualised falls reduction strategies, transfer of unwell residents to the DHB hospital and provision of staff training. The resident and/or family had been informed of the sampled events. Residents and family members interviewed noted that communication processes have improved significantly in recent months.</p> <p>A review of ten incidents randomly selected occurred. While most events had been investigated and responded to in a timely manner, this was not always documented as part of the incident</p>	<p>Incidents are being reported by staff and sampled events investigated and followed up in a timely manner; however, the events are not always closed in a timely manner and the investigations, actions taken and evaluations are not always recorded/linked/cross referenced between incidents reports and residents' clinical records as these are separate electronic systems.</p>	<p>Ensure a process is implemented to ensure any investigations and actions taken in response to reported adverse events are clearly linked to the adverse event report, and events are closed as and when appropriate.</p> <p>180 days</p>

		<p>management system and/or cross referenced to interventions taken as noted in the applicable residents' clinical record. For example, following a fall or pressure injury, or following an investigation about a resident's lost property. A number of events were noted to still be open despite the resident's clinical record noting the issue had been fully addressed. For example, a fall that resulted in a wound. Staff noted having searched for a resident's property that was reported missing. The facility manager advised the missing items could not be located, and the incident remains open at least 8 weeks after the event was reported. The new clinical management team (clinical manager and the two unit coordinators) are still familiarising themselves with the incident/accident processes and how best to link the outcomes of investigations and actions required and/or implemented and any subsequent evaluations that have been undertaken between the electronic incident reporting platform and the electronic residents' clinical records, as these two systems are stored/maintained separately. One sampled event had yet to be investigated, however this event was newly reported.</p> <p>The electronic platform where events are reported has a dashboard that enables real time monitoring of the number of reported events and themes and trends; however, this is not occurring as yet (refer to 1.2.3.7). There is also the ability</p>		
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		to benchmark incident/accident data with other providers. The facility manager and clinical manger advised this is not occurring at present, while the focus is on ensuring the incident reporting and management systems are robust and implementing the new management structure; this is intended in the future.		
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>Staff orientation includes all necessary components relevant to their role. There is a workbook and checklist that staff are required to work through and complete within three months of employment. Staff interviewed reported that their orientation process suitably prepared them for their role and responsibilities. However, records are not available to demonstrate that all staff have completed the requirements. Orientation records were missing from at least six staff files reviewed for staff employed more than three months.</p>	<p>While staff advise they are provided a comprehensive orientation programme, records were not consistently available to demonstrate that this had been completed.</p>	<p>Ensure records are retained to verify that staff have completed the organisation's orientation programme within the required timeframes.</p> <p>180 days</p>
<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 Moderate	<p>Training is occurring on topics relevant to the services provide onsite and records of attendance are maintained. Topics provided since July 2019 have included restraint minimisation and safe practice, self-care, moving and handling, complaints/adverse event reporting, customer service, medicine management, the use of a new piece of equipment, male catheterisation, and undertaking a nutritional assessment of</p>	<p>While ongoing training/education is occurring, a training plan has not yet been developed for 2020.</p> <p>A staff member is not always on duty with a current first aid certificate.</p> <p>Records were not available to demonstrate that four registered nurses administering medicines have completed the medicine</p>	<p>Develop and implement a training plan.</p> <p>Ensure a staff member with a current first aid certificate is always on duty.</p> <p>Ensure records are retained that demonstrates staff independently administering medicines have been assessed as competent to</p>

		<p>older people. Some staff are working to complete an industry approved qualification in dementia care with group classes occurring. The interim clinical manager is an approved assessor and is noted to be continuing to support staff in this training. Staff advise they can request education topics. While education is occurring, a training plan for 2020 has yet to be developed.</p> <p>The registered nurses and enrolled nurses are required to have a current first aid certificate. At least three applicable staff are overdue for this training and they have been rostered on shifts with staff who have yet to complete the first aid training requirements.</p> <p>There are processes in place to assess that staff involved with administering medications are competent to do so. The initial assessment occurs as a component of orientation and then is required to be completed annually thereafter. Records were not available to demonstrate that four registered nurses, independently administering medicines to residents have completed the medicine competency assessment programme as their orientation related records were not available for review. The annual medicine competencies had been completed for all applicable staff.</p> <p>Staff are required to have annual performance appraisals. One sampled staff member employed had a review three months after employment. The most recent annual appraisal present in</p>	<p>competency assessment programme.</p> <p>Annual performance appraisals of staff are not occurring. The appraisals were overdue for all sampled staff who have been employed more than 12 months.</p>	<p>do so.</p> <p>Undertake annual staff performance appraisals.</p> <p>90 days</p>
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		the ten staff files sampled was dated as occurring in October 2017. Annual appraisals have not occurred for any of the six staff employed for more than 12 months. The facility manager verified staff performance appraisals are not occurring.		
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Staffing numbers have increased since the new chief executive and facility manger were appointed. There are now always two registered health professionals (RHP's) on duty for every shift. This may be two registered nurses or a registered nurse and an enrolled nurse. There is a minimum of three health care assistants (HCA) on duty, with a fourth HCA being added to the night shift roster in the week prior to audit due to residents' identified care needs. A reduction in HCA hours is planned for morning and afternoon shifts commencing with the roster commencing 2 February 2020. There were currently eight HCAs rostered on for the full morning shift and between two and three HCAs rostered for part hours on a morning shift. The facility manager advised there are sufficient staff employed for Bethesda Care at full occupancy. In addition to the two RHPs on duty, a unit coordinator (registered nurse) has been appointed to each of the two units working weekday mornings. HCAs are rostered to work in designated units, although help in other units as and when required. The facility manager</p>	<p>Rostered staffing exceeds the requirements of the safe staffing indicators and is stated to reflect a resident acuity assessment process. With the exception of the spreadsheet that details the template roster, a document detailing this staffing process/guidelines and resident assessment process was not able to be located during audit.</p>	<p>Ensure the documented rationale used to determine safe staffing and skill mix is available for reference when developing the staff roster.</p> <p>180 days</p>

		<p>develops the HCA roster, based on information provided (a spreadsheet) by the clinical manager that notes how many HCAs are to be rostered each day per unit for full or part of each shift. The management team identified that the staffing hours is based on the calculation of hours required per resident based on the use of a resident acuity tool and an associated policy. The acuity tool and staffing framework/policy could not be located during audit. Residents and family members interviewed confirmed there are sufficient staff rostered to provide the required care. Staff advised they normally have enough time to provide residents with their required care.</p> <p>There is a maintenance person and gardener who work fulltime. The clinical manager (who is a registered nurse), the chief executive and the facility manager work weekday mornings. A physiotherapy aid assists residents four days a week from 8 am to 2 pm. A diversional therapist and an activities assistant both work weekdays from 8 am to 4.30pm. There is a chaplain, administration/reception staff and designated staff employed for household, laundry and catering services.</p>		
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing,</p>	<p>PA Moderate</p>	<p>Policies and procedures are available to guide staff practice. An online patient medication management system was in use except for short stay or respite care residents. Staff are provided with a unique identification logon to these</p>	<p>Eight out of 51 residents electronic medicine charts are overdue the three-monthly general practitioner review. The temperature of the medication</p>	<p>Ensure all residents' medicines are reviewed at least three monthly by the general practitioner and that this review is noted on the</p>

<p>dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>records. Medications were stored safely in a locked medication room. A safe medication administration practice was witnessed during the medication administration rounds on the day of audit.</p> <p>There was no evidence that monitoring of the medication fridge temperature has occurred since December 2019.</p> <p>The three-monthly medication review was not documented as occurring in the medicine record of eight sampled residents. Reviews had been documented for all the other applicable residents.</p> <p>Pro re nata (PRN) medication charts sighted contained duplicate entries for example, one gram of paracetamol was charted for administration four times a day, with paracetamol or paracetamol/codeine also charted as a pro re nata medicine. Where duplicate entries were noted, staff had not administered the medicines incorrectly in the sampled files. The route of administration was not correctly prescribed in six of the twelve residents' medication records sampled.</p> <p>A resident receiving respite care did not receive one dose of medications and another dose was given but not signed for and sample signatures are not maintained of staff who administer medications to the residents with paper based medicine records.</p>	<p>refrigerator is inconsistently monitored.</p> <p>Six out of 12 residents' pro re nata (PRN) medication charts sighted contained duplicate entries or the route of administration was not correctly prescribed.</p> <p>A resident receiving respite care did not receive one dose of medications (the medicines were still present in the blister pack), and another dose was given but not signed for.</p> <p>In addition, for another four medication entries the time and date of administration was noted but the staff member administering was not noted/signed. Sample signatures are not maintained for medicines given via paper-based records.</p>	<p>medicine record.</p> <p>Review pro re nata medications to remove duplication and ensure the route of administration is correct.</p> <p>Ensure all medicines are given as prescribed or noted to be refused or withheld and appropriate records are maintained.</p> <p>Ensure all medication administered is appropriately documented at the time of administration.</p> <p>Maintain a sample signature record for medicines given via paper-based records.</p> <p>Monitor the medication refrigerator temperature consistently.</p> <p>90 days</p>
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<p>Criterion 3.5.7</p> <p>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.</p>	<p>PA Low</p>	<p>The surveillance programme in place is appropriate to an aged related residential care setting. Individual resident infections were reported and managed appropriately by staff with short term care plans developed and implemented. Changes in health conditions such as infections were discussed during the staff handover, and the resident and family informed.</p> <p>While individual infections are being reported, there is currently no evidence of analysis of infection control data, themes and trends over time or communication of these results with care staff.</p>	<p>Whilst individual infections are being reported and appropriately managed; there is no evidence of analysis of infection control data and including themes and trends over time or communication to relevant staff.</p>	<p>Ensure the results of the infection surveillance programme are regularly analysed (including themes and trends), and the results are communicated to appropriate staff.</p> <p>180 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.