

Bupa Care Services NZ Limited - NorthHaven Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	NorthHaven Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 18 April 2018 End date: 19 April 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	103



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

Bupa NorthHaven provides hospital, rest home, psychogeriatric and residential disability - intellectual/physical for up to 106 residents. On the day of audit there were 103 residents.

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

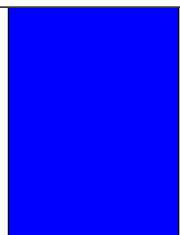
The care home manager has been in the role for five years and is supported by a clinical manager (registered nurse), the Bupa regional operations manager and quality and risk team.

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

This certification audit identified that improvements are required around dating eye drops.


Continuous improvement ratings have been awarded around good practice, quality initiatives and health and safety.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Staff endeavour to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Code of Health and Disability Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with the resident's representative. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are managed, and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The care home manager has been in the role for five years. She is supported by an experienced 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 is

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

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

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

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

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. There are snacks available at all times.

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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have hand basins, and some have ensuites. There are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. The psychogeriatric unit's outdoor areas are safely fenced. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services. Laundry is completed on-site.

There are shared and single rooms within the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are ventilated and heated. 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 for at least three days. There is a staff member on duty on each shift who holds a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. On the day of audit, there were 18 residents using restraint and no residents with an enabler. Restraint management processes are being implemented.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	48	0	1	0	0	0
Criteria	3	97	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has a range of policies and procedures to ensure that resident's rights are protected. Staff interviewed (four caregivers, five registered nurses, and the diversional therapist) were aware of consumers' rights and were able to describe how they incorporated consumer rights within their service delivery. Seven residents (one rest home and six hospital including one younger person disabled) and six family members (two hospital and four psychogeriatric) agreed that the service respects residents' rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (six hospital including one young person with a disability, one rest home and four psychogeriatric). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' charts and all psychogeriatric residents have enduring power of attorney and NASC referrals.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There is a policy that describes the role of advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer and includes advocacy contact details. The information pack provided to family/whānau/EPOA at the time of entry to the service provides family with advocacy information. Advocacy support is available.</p> <p>Interviews with staff and relatives confirms that they are aware of advocacy services and how to access an advocate. The complaints process includes informing the complainant of their right to contact an advocacy service for support.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The activity programme contains links to the local community including: local churches; volunteers; nearby schools; entertainers; and cultural groups. Interview with staff and families confirms that residents are supported as able, to maintain their previous interests. Visiting can occur at any time.</p> <p>The service is responsive to young people with disabilities accessing the community, resources, facilities and mainstream supports such as education, public transport, and primary health services in the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. There are complaint forms available. Information about complaints is provided on admission. A suggestions box is held at reception. Interviews with residents and families demonstrates their understanding of the complaints process. All staff are able to describe the process around reporting complaints.</p> <p>A complaints register is being maintained. There have been no complaints lodged for 2018 year-to-date. Six complaints were lodged in 2017, some are logged on a paper-based system and the complaints logged after October have been entered onto the electronic system.</p> <p>All complaints held on both registers include evidence of an investigation, corrective actions (where indicated) and resolutions. Complaints are linked to the quality and risk management system. Discussions with relatives confirms that issues are addressed promptly and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>There are posters displaying the Code. The service is able to provide information in different languages and/or in large print if requested. On entry to the service the care home manager or clinical manager discuss the Code with family/whānau/EPOA. Information relating to the Code is given in the information pack to the next of kin or</p>

<p>Consumers are informed of their rights.</p>		<p>enduring power of attorney (EPOA) to read and discuss. Family forum meetings are held quarterly and provide relatives an opportunity to discuss any concerns.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. Individual preferences are identified during the admission and care planning process with family involvement. All staff receive the code of conduct on employment, which includes respect for residents and the service vision includes respect and independence. Staff were observed respecting residents' privacy, for example, knocking on doors and referring to residents by their preferred names. Care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' cares. The service encourages residents to have choice where able, such as voluntary participation in daily activities. Family members interviewed confirm that staff promote the residents' independence wherever possible and that residents' choices are encouraged. There is an implemented abuse and neglect policy and staff have completed training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has established Māori cultural policies to help meet the cultural needs of its Māori residents. Bupa has developed Māori Tikanga best practice guidelines. The service has established links with Te Herenga Waka O'Ōrewa Marae and are able to utilise the Kaumātua for blessings and maintaining other Māori values as required by staff, residents and family members. Staff training includes cultural safety. A cultural assessment is completed during the resident's entry to the service. There is one resident in the PG unit that identifies as Maori. Cultural needs were identified in the resident's care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic,</p>	<p>FA</p>	<p>The service has established cultural policies aimed at helping to meet the cultural needs of the residents. Relatives interviewed report that they are satisfied that the residents' cultural and individual values are being met. Information gathered during assessment including residents' cultural, beliefs and values, is used to develop a care plan, which their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents.</p>

cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's orientation to the service and is signed by the new employee (sighted in all eleven employees' files audited). Professional boundaries are defined in job descriptions. Interviews with staff 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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Evidence-based practice was evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, twenty-four hours a day. The service receives support from the district health board which includes visits from specialists (e.g., wound care and mental health), staff education and training. A contracted GP visits the service three times weekly and provides after hours on-call cover. A psychogeriatrician and a mental health nurse specialist visits the facility regularly and as required. Physiotherapy services are provided for eight hours per week. There is an education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community, which includes (but is not limited to) advocacy and entertainers.</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>On admission, all residents are provided with an information pack, which gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau, including information specific to a secure dementia environment.</p> <p>Regular contact is maintained with family including if an incident or care/health issue arises. This was evidenced in ten incident forms reviewed from across the service.</p> <p>Family members interviewed stated they were well informed and involved in residents' care.</p> <p>There are quarterly family and residents' meetings where any issues or concerns to residents are able to be discussed. The service has policies and procedures available to enable access to DHB interpreter services and residents (and family/whānau), are provided with this information in resident information packs.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>Bupa NorthHaven provides hospital, rest home, psychogeriatric and residential disability - intellectual/physical for up to 106 residents. On the day of audit there were 103 residents. There were two rest home level residents</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>and 59 hospital level residents in the hospital/rest home units including one resident under the residential disability contract - physical. There were 42 residents in the two psychogeriatric units.</p> <p>Bupa NorthHaven is a two-storey building with hospital/rest home services being provided on the first floor. This unit has five dual-purpose beds, two of which were occupied by rest home residents. There is another hospital unit located on the ground floor. Two psychogeriatric units (one with 20 beds and one with 22 beds) are also located on the ground floor.</p> <p>The service is managed by a care home manager who has been in the role at NorthHaven for five years, she is also a registered nurse and has worked in aged care management for over 25 years. The clinical manager has been in the role for four years. The management team is supported by the wider Bupa management team including a regional operations manager.</p> <p>Staff and family interviewed, praised the management team and spoke highly of the leadership and guidance that is provided to staff and support to family members.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the managers and staff confirms their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff,</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>as evidenced in meeting minutes.</p> <p>An internal audit programme is in place. In addition to scheduled monthly internal audits, a facility health check is conducted six-monthly by an external Bupa representative. Data collected (e.g., falls, medication errors, wounds, skin tears, pressure injuries, complaints and challenging behaviours) are collated and analysed for each resident involved. Quality data and results are documented in the quality and staff meetings and communicated to staff. Corrective actions are implemented where opportunities for improvements are identified. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented.</p> <p>The health and safety programme includes' specific and measurable health and safety goals that are regularly reviewed. The care home manager is the health and safety officer. There are also two elected health and safety representatives. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed.</p> <p>Strategies are implemented to reduce the number of falls. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers. Continuous improvements have been awarded around falls management and prevention and health and safety.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff. Adverse events are trended and analysed with results communicated to staff. There were twenty falls, three bruises and seventeen skin tears recorded for February 2018. A sample of ten documented that clinical follow-up of residents is conducted by a RN and witnessed falls include neurological observations.</p> <p>Discussion with the care home manager confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. There has been one section 31 completed since last audit as a result of a pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>FA</p>	<p>There are human resources management policies in place, which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are retained. Eleven staff files reviewed (three caregivers, four RNs, one kitchen manager, one administrator, one housekeeper and one diversional therapist) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions.</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Caregivers complete an aged care education programme as part of their induction, which meets the New Zealand Quality Authority (NZQSA) requirements.</p> <p>Bupa has a comprehensive annual education schedule. All staff are encouraged to attend at least 1 x educational session per month. NorthHaven seeks feedback from staff on the content of educational sessions and adjust to meet their learning needs – this has resulted in improved attendance numbers. Mop up sessions are also conducted to ensure all staff have opportunity to learn through attending sessions at varied times. The education programme being implemented includes in-service training, competency assessments, impromptu toolbox talks and study days.</p> <p>All caregivers are registered to complete their foundation skills in health and social well-being on employment and are assisted to complete within 3 months of employment</p> <p>New staff have a photo and brief ‘three things about me’ posted onto the staff noticeboard to assist their integration into the team.</p> <p>The kitchen manager has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on-site. Chemical safety training is included in staff orientation and as a regular in-service topic.</p> <p>RNs are in the process of completing their professional development recognition portfolio (PDRP). Six of 17 RNs have completed interRAI training. The care home manager, clinical manager and staff attend external training, including sessions provided by the district health board. All RNs maintain up to date practice attending in house education at least 1 x session per month. Staff also delivering education to non-qualified staff as part of their own development. Training has also been provided around caring for younger people which links into a number of different in-services.</p> <p>Ten RNs at NorthHaven also attended the RN Bupa study days in the last year.</p> <p>All eighteen caregivers who work across the psychogeriatric units have completed the required dementia standards.</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</p>	<p>FA</p>	<p>A staff rationale and skill mix policy is in place. Staff rostered on to manage the care requirements of the resident meet contractual requirements. Both the care home manager and clinical manager work full-time Monday-Friday.</p> <p>Staff by unit is as follows;</p> <p>Hospital downstairs, two wings of up to 20 residents each. There were 38 residents in the two wings on the day of audit.</p>

<p>service providers.</p>		<p>AM; two RNs, this includes the unit coordinator who is supernumerary two days a week and six caregivers (all long shifts). PM; two RNs and four caregivers (three long shifts and one short).</p> <p>Hospital upstairs; two wings of 12 residents each. There were 23 residents in the two wings on the day of audit.</p> <p>AM One RN and four caregivers (three long shifts and one short finishing at 2pm) PM; one RN and three caregivers (one long and two short shifts – finishing at 9.00 pm)</p> <p>For the night shift across the two hospital floors, there is one RN. There are four caregivers (two per unit).</p> <p>Psychogeriatric units, there are two units, one with up to 20 residents and one with up to 22 residents, both were full on the day of audit.</p> <p>Psychogeriatric unit, complex needs (20 residents)</p> <p>AM; one RN and three caregivers (all long shifts), PM one RN and two caregivers (both long shifts).</p> <p>Psychogeriatric unit, less complex needs (22 residents).</p> <p>AM one RN and three caregivers (all long shifts), PM one RN and two caregivers (long shifts)</p> <p>In addition to the above staffing there is a ‘floating’ caregiver between the two units; 7.00 am to 1.00 pm and 4.00 pm to 9.00 pm.</p> <p>For the night shift for the two psychogeriatric wings, there is one RN and three caregivers (one per unit).</p> <p>RN staffing meets contractual requirements for psychogeriatric levels of care. The clinical manager along with the care home manager, provides after hours on-call cover.</p> <p>Interviews with staff and family members identifies that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The 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.</p>
<p>Standard 1.3.1: Entry To</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission</p>

<p>Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>policy. The service has an information pack available for residents/families at entry. This includes information around specialist services of a psychogeriatric unit. All resident files reviewed included a NASC approval for the level of care.</p> <p>The admission agreements reviewed meet the requirements of the ARCC and ARHSS. Exclusions from the service are included in the admission agreement. All eleven admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. Staff have up-to-date medication competencies and there has been medication education in the last year. RNs have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are not always dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twenty-two medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	FA	<p>The service has a head cook who covers Monday to Friday and another cook who works weekends. There are two kitchenhands per shift. All staff have food hygiene certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from the kitchen to the dining room in one hospital wing and transported to the other wings in hot boxes. Meals taken to rooms on trays have covers to keep the food warm. Special equipment such</p>

<p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>as lipped plates are available. On the day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. The evening meal is left prepared by the cook and reheated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked (including the reheated evening meal) and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by the Bupa dietitian. Snacks are available at all times.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The Bupa assessment booklet is completed and the interRAI assessment tool is implemented. InterRAI assessments had been completed for all long-term residents whose files were sampled. Care plans sampled were developed on the basis of these assessments. Challenging behaviour assessments were completed for residents with behaviours that challenge that linked to specific dementia care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused,</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, podiatrist, wound care specialist and mental health</p>

<p>integrated, and promote continuity of service delivery.</p>		<p>care team for older people. The management of behaviours that challenge was documented in the files reviewed including triggers to behaviour and interventions to manage outbursts.</p> <p>The care staff interviewed advised that the care plans were easy to follow and assisted them when caring for the residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. The four resident files sampled from the psychogeriatric unit all included management of nutrition and monitoring for weight loss.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls, or falls where residents hit their heads.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided, including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. Photos of wound progress are taken. There are currently seventeen wounds being managed. There are currently three pressure injuries being managed and wound care plans were in place. A section 31 was completed for the unstageable pressure injury (now a grade three). There has been input from the GP and wound care nurse specialist.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. There is liaison with the mental health for older person's team.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>There is one diversional therapist who works 35 hours a week Monday to Friday. There are two activities assistants who work 26 hours a week between them, over seven days. They are currently looking to employ a third activities assistant. The two activity assistants are split evenly between hospital and PG units. That leaves DT with supervision and assisting in both units. On the days of audit, residents were observed playing quoits, bingo, and participating in sit exercises and listening to an entertainer.</p> <p>There is a weekly programme in large print on noticeboards in all unit lounges. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. This is particularly noticeable in the psychogeriatric units where residents' concentration spans are often short. Activities include exercises, games, quizzes, music, sensory dough play</p>

<p>service.</p>		<p>and walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are interdenominational church services held in the facility every second and fourth Wednesday. Catholic Church members come in to give communion. There are van outings twice weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>A pet therapy team visit every Wednesday. The nurse manager's puppy comes in daily Monday to Friday. There is a cockatiel on one wing and fish on another.</p> <p>There is community input from clubs, pre-schools and schools. Some residents attend Stroke club and Senior Moments.</p> <p>The young person with a disability (YPD) is both physically and cognitively impaired but joins in activities if able. The facility takes the YPD resident home in the van fortnightly, for lunch with the family.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly. Resident meetings are held six weekly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The eleven long-term care plans reviewed had been evaluated by the RNs six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are one monthly reviews by the GP for all hospital residents and three monthly for all rest home and psychogeriatric residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people, speech language therapist and dietitian. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, goggles and face shields are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness. There is a maintenance person on-site for 40 hours a week. Contractors are used when required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted, and communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade and the psychogeriatric outdoor areas are safely fenced. There is safe access to all communal areas.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for all levels of care.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>There are sixteen single rooms with hand basins, twelve double rooms with hand basins and four rooms with ensuites in one hospital wing. There are 24 single rooms with hand basins and twelve rooms with shared ensuites in the other hospital wing. There are six single, and seven double rooms in one psychogeriatric wing</p>

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>and six single and eight double rooms in the other. All psychogeriatric rooms have a hand basin. There are sufficient communal showers and toilets. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and in larger ones, a hoist if appropriate. There are privacy signs on all shower/toilet doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is sufficient space in each room to allow care to be provided and for the safe use of mobility equipment, shower chairs and hoists. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or where visitors may sit. All wings have attractive outdoor areas with easy access. Each wing has a dining area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	<p>FA</p>	<p>Laundry is done on-site by four laundry workers who work shifts. The laundry is divided into a 'dirty' and 'clean' area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>cleaner's trolley were labelled. There is a sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations, including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. A generator is able to be hired if required.</p> <p>There is an approved fire evacuation scheme in place and there are six monthly fire drills. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated, light up on corridor lights that are visible from all areas in the facility in addition the care team carry pagers that alert discreetly if call bells are activated Security policies and procedures are documented and implemented by staff. The buildings are secure at night with afterhours doorbell access and there is security lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed</p>	<p>FA</p>	<p>The 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.</p>

<p>environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>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 at head office. Annual quality and infection control goals are set at the beginning of the year. The facility has developed links with the GPs, local laboratory and the infection control and public health departments at the local DHB.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>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.</p> <p>Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control 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. 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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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. Infections are included on a monthly register and a monthly report is completed by the infection control officer. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly. Meeting minutes are made available to staff.</p> <p>Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Infection control data is collated monthly and discussed at the staff meetings. The infection control programme is linked with the quality management programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a regional restraint group at an organisation level, which reviews restraint practices. The quality committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</p> <p>There are eighteen residents requiring the use of a restraint and there are no residents requiring the use of an enabler. Restraint residents include; nine at hospital level; (two with T belts, one low bed, and six bedrails), there are eight residents with restraint in the psychogeriatric unit (seven with a T belt and one bedrail) and one rest home level resident with environmental restraint.</p> <p>All restraint use is recorded on a restraint register. Files for five residents with restraint were reviewed. Assessments, consents and monitoring is documented. All files evidence that a documented 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</p>

		organisational level.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical manager is the restraint coordinator. The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions include the restraint coordinator, clinical manager, RNs, resident or family representative and medical practitioner. Restraint use and review is conducted at restraint meetings and reported to the quality team meeting.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, clinical manager, RNs, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Assessments and consent forms are fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated, justified and approval processes are followed. There is an assessment form/process that has been documented for all restraint files reviewed. The restraint coordinator was interviewed. The five files reviewed have a completed assessment form and a care plan that reflects risk. Monitoring forms are present in the files reviewed. Consent forms detailing the reason and type of restraint are completed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has a documented evaluation of restraint every three months. In the five restraint files reviewed, evaluations have been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at restraint meetings, quality and staff meetings. Evaluation timeframes are determined by risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator and/or clinical manager. The restraint coordinator's monthly reports evidence reporting at the restraint meetings and RN/clinical meetings. Restraint use is also reviewed as part of the quality meeting.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Medications are prescribed electronically. Pharmacy delivers the medications and checks them in with a RN. The pharmacy completes six monthly checks of medications. All medications are stored safely. Medication fridge temperatures are checked daily. Eye drops are not always dated when opened. All medications that are no longer required are returned to pharmacy for disposal.	Two out of two eye drops opened on the 18 April 2018 were not dated.	<p>Ensure all eye drops are dated when opened.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>NorthHaven Hospital has a long-standing, supportive senior team, consisting of an experienced nurse care home manager, experienced clinical manager and unit coordinator. Nursing staff are supported to complete their interRAI training, additional post graduate study and professional development.</p>	<p>From April 2017, NorthHaven has been involved in an initiative called releasing time to care which has seen the team work more collaboratively to develop new ways of thinking, of working, looking at processes, systems and people to release more time to spend with residents. This initiative has released 8,558 hours back into direct resident care through initiatives such as: sorting and standardising storage and clinical rooms, and setting a standard for high use rooms to prevent lost time searching for resources, the nursing handover process has been reviewed and standardised. Staff identified that they often spend time looking for other staff to assist them, so NorthHaven Hospital has introduced a working in pairs model of care and introduced flags on resident doors to identify where staff are in resident’s room.</p> <p>Staff recognition includes rewards: Staff are recognised each month by their colleagues who nominate in the wonderful staff nomination box giving examples of observations or feedback</p>

			<p>when they have seen staff go above and beyond in their role.</p> <p>Eighty-eight percent of staff have completed bronze Personal Best training, which has seen great residents focused initiatives implemented such as: Creating a history book for a resident of their life story/creating fiddle muffs for dementia residents, making a mobile kitchenette to be used to encourage ladies to participate in everyday household chores, holding film matinees complete with popcorn.</p> <p>Staff interviewed stated that the service is very supportive and that they have a great team. Families and residents were complimentary around the staff and care. The resident survey Net promoter score increased for minus 11 to 0 for the 2017 survey.</p>
<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>	CI	<p>There is a comprehensive quality and risk management process in place. There are a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Bupa NorthHaven is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified.</p>	<p>The service implemented a falls prevention programme during 2017, which focused on identifying strategies for the reduction of resident falls. Strategies included; In-depth analysis of falls including; time and place, and staffing has been documented showing a link between staff absences and increased falls risk. This information has been shared with staff as a shared noticeboard and through meetings.</p> <p>A monitoring roster has been implemented where those of higher falls risk/increased vulnerability can be group monitored. All residents who have fallen in the previous month are referred to physiotherapist and physio assistants for review of mobility and safe transfer plans. Rest periods are implemented for those where falling has been directly linked to tiredness later in the day. All residents are reviewed for use of hip protection. Use of protective equipment reviewed such as low beds, perimeter mattresses, landing mats/sensor alert mats, use of swim noodles to tilt mattress edges/intentional rounding.</p> <p>A 10% fall in falls rates has been documented for 2017 and although falls have crept up slightly for 2018 year-to-date, analysis by the service evidences that this is due to some frequent fallers for whom all interventions have been</p>

			implemented. The service has reviewed these and implemented new strategies as a result of the evaluation.
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	CI	<p>Bupa NorthHaven has a mission statement that includes 'where everybody is somebody'. Their commitment to staff safety is included in the mission. The Bupa SMILE, staff wellbeing programme is fully implemented with staff enjoying monthly themed activities and initiatives to maintain a healthy lifestyle and wellbeing, together sharing healthy meals, recipes, inter-unit sports and exercise, ice blocks in hot weather, and mini health checks, including free flu vaccination clinic on-site.</p>	<p>As part of the service commitment to staff wellbeing, the facility implemented a staff safety and safe environment initiative. Strategies included: a focus on staff health and safety and hazard knowledge and practice through training and recognising good practice 'in the moment'. Designated health and safety champions are empowered to support and work with staff to encourage good practice. Moving and handling training is repeated over the year to ensure that all staff are updated and trained. A review of incidents suggested that staff related incidents were linked to the management of challenging behaviour with residents. Additional education has been provided around challenging behaviour training and interventions. Meeting minutes document that regular evaluations and review of all incidents has been conducted. The incidence of staff injuries has decreased by 25% from 2017 to year-to-date.</p>

End of the report.