**Bupa Care Services NZ Limited - Naomi Courts Rest Home**

**Current Status:** **01-Aug-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Naomi Courts rest home is part of the Bupa group. The service is certified to provide dementia level care for up to 50 residents. On the day of the audit there were 40 residents. The Manager has over 18 years' experience managing aged care facilities and over five years in her role as manager at Naomi Courts. She is also supported by an experienced clinical manager and four registered nurses. Staff turn-over has been low. There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the Bupa quality and risk management programme that is individualised at well-established at Naomi Courts. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service is commended for achieving six continued improvement ratings relating to good practice, quality initiatives/governance, implementation of quality initiatives, and quality actions as a result of incident reporting and the education programme.

**Audit Summary AS AT** **01-Aug-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit01-Aug-13 | Assessment |
| 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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| **Organisational Management** | Day of Audit01-Aug-13 | Assessment |
| 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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Continuum of Service Delivery** | Day of Audit01-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit01-Aug-13 | Assessment |
| 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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| **Restraint Minimisation and Safe Practice** | Day of Audit01-Aug-13 | Assessment |
| 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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| **Infection Prevention and Control** | Day of Audit01-Aug-13 | Assessment |
| 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** |

**Audit Results AS AT** **01-Aug-13**

**Consumer Rights**

Naomi Courts endeavours to provide care in a way that focuses on the individual residents' quality of life. Bupa has introduced an initiative "personal best" whereby staff undertake a project to benefit or enhance the life of a resident(s). Naomi Courts have a number of staff involved in the programme. Residents and relatives spoke positively about care provided at Naomi Courts. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. A continuous improvement has been awarded against best practice.

**Organisational Management**

Naomi Courts has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Naomi Courts is benchmarked in one of these (dementia). The robust systems for quality and risk management are continually being reviewed at both an organisational level and at Naomi Courts. Benchmarking and audit data demonstrate that they have achieved good standards of care and service. Quality actions have resulted in a number of quality improvements for both residents and staff. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering. Continuous improvement ratings have been awarded around the implementation of the quality system and education programme.

**Continuum of Service Delivery**

 The service has a comprehensive admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Lifestyle plans demonstrate service integration. Lifestyle plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. The activities programme is facilitated by activities officer. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.

All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented. The service has implemented a number of quality initiatives around the food service and weight management with positive outcomes identified.

**Safe and Appropriate Environment**

The building holds a current warrant of fitness. Rooms are individualised and spacious. There are three secure dementia wings. The external areas are well maintained and gardens are attractive. There is easy access to secure and safe walking paths from each unit. Outdoor seating, shade and a gazebo is available. There are spacious lounge's within each area. There are adequate toilets and showers for the client group. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. All key staff hold a current first aid certificate. Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The facility has gas fired central heating and temperature is comfortable and constant and able to be adjusted in residents rooms to suit individual resident preference.

**Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The service is restraint-free and staff complete competencies in relation to the restraint-free philosophy.

Restraint usage throughout the organisation is monitored and benchmarked. Review of restraint use across the group is discussed at regional restraint approval groups. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

**Infection Prevention and Control**

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is responsible for coordinating/providing education and training for staff. Infection control training is provided at least twice each year 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 co-ordinator 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 on-going training in infection control.

Naomi Courts Rest Home

Bupa Care Services NZ Limited

Certification audit - Audit Report

Audit Date: 01-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| **Provider Name** | Bupa Care Services NZ Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Naomi Courts Rest Home | 8 Clifford Avenue |       | Nelson |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Certification audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 01-Aug-13 **End Date:** 02-Aug-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

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| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RCompN, Health audit cert | 12.00 | 6.00 | 1-Aug-13 to 2-Aug-13 |
| Auditor 1 | XXXXXXX | RN, Health audit cert | 12.00 | 5.00 | 1-Aug-13 to 2-Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 13.00 | **Total Audit Hours** | 37.00 |
| **Staff Records Reviewed** | 7 of 50 | **Client Records Reviewed** *(numeric)* | 7 of 40 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 7 |
| **Staff Interviewed** | 13 of 50 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 6 |
| **Consumers Interviewed** | 0 of 40 | **Number of Medication Records Reviewed** | 14 of 40 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 30 day of August 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

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| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Naomi Courts Rest Home | 50 | 41 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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2 Restraint Minimisation and Safe Practice

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3. Infection Prevention and Control

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Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | CI | 1 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:0 CI:1 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:1 FA:22 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | CI | 1 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | CI | 2 | 6 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 1 | 1 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | CI | 1 | 3 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:3 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:5 FA:17 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:21 PA:0 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 8 |

1. Infection Prevention and Control

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 5 **CI:** 4 **FA:** 41 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 6 **FA:** 87 **PA:** 0 **UA:** 0 **N/A:** 8 |

# Corrective Action Requests (CAR) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:01-Aug-13 End Date: 02-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:01-Aug-13 End Date: 02-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| **Std** | **Criteria** | **Evidence** |
| 1.1.8 | 1.1.8.1 | **Finding:**Bupa has robust quality and risk management systems and these are implemented at Naomi Courts supported by a number of meetings held on a regular basis including (but not limited to); quality, staff, residents, qualified nurses, IC, kitchen and health and safety. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes have been implemented at Naomi Courts. Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. A residents/relatives association was also initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Naomi Courts - 40% staff have gold, 62.9% staff have silver and 77.1% staff have bronze. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care. Benchmarking results are provided and reviewed at Naomi Courts. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Naomi Courts through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting. The facility manager at Naomi Courts has been involved in presenting at the Leadership training and mentoring new managers within the organisation. Naomi Courts is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and staff suggestions. QI corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. eg: med error above KPI in June 13. Recommendations were also reviewed through the qualified staff meeting, a RN completed a 'reflective practice' and the effectiveness of actions established were reviewed . Quality action forms are also established at Naomi Courts for areas that staff/management identify as requiring improvement. The following have been established (but not limited to); separating medication from meals – making meal times dedicated to the eating experience, assisting family to purchase correct size footwear, health checks of ears. Toolbox talks are routinely completed that link to benchmarking indicators at Naomi Courts. Actions are progress monitored and evaluated for effectiveness. Wine and cheese nights are established for families that include a guest speaker and families are invited to 'cooked breakfast' mornings on a Friday. The manager stated this is a good time for the management team to catch up with relatives that only visit in weekends. |
| 1.2.1 | 1.2.1.1 | **Finding:**Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. Facility Manager provides a documented weekly report to Bupa Operations Manager. The operations manager visits regularly and completes a report to the General Manager Care Homes. Naomi Courts is part of the Southern Bupa region which includes 11 facilities. The managers in the region teleconference weekly,. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Naomi Courts and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Naomi Courts annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Naomi Courts has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa Way has been launched in 2011 – the Bupa Way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans were rolled out in 2011. The new care plan builds on the "Bupa Way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. The B-fit organisational goal is well implemented at Naomi Courts. The organisation has commenced a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Naomi Courts is very proud of the introduction of ensuring no medications are administered during the meal experience (quality initiative). This has been given high praise by their GPs and families. GPS (staff survey) 2012 results have put Naomi Courts in the top eight Bupa facilities with communication being one of their strong strengths.  |

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| 1.2.3 | 1.2.3.6 | **Finding:**There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Naomi Courts is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of meetings and discussion with the management team, there continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established at Naomi Courts for indicators above the benchmark. i.e.: June 2013 - medication errors. Analysis of why an error of insulin occurred, resulted in training with RNs around best practice and change of practice. Naomi Courts has taken on board the Bupa drive for reduction in the use of anti-psychotics with their residents and on-going evaluation of effectiveness of anti-psychotics for those prescribed. From 42% in January 13 to 39% in June 13. Other improvements noted include (but not limited to); Following an education session from the Hearing Assc, they established a Quality Action around arranging regular ear checks. The outcome included contracting the local association to complete monthly ear health checks and monitoring and cleaning of hearing aids. A resident weight management initiative was implemented following an education session by Mr Tor Bogno of Sweden. He discussed the benefits of drinking (sugary drinks?) prior to meals to stimulate appetite due to the rise in blood sugar level then the fall leading to the crave for food-hunger. Naomi Courts developed a quality initiative with all staff, organised a drinks trolley with cordial juice and changed cordial time to 30 mins prior to meals. As part of their evaluation they identified significant change in weight management. Increase and stabilisation of weights. Positive feedback from dietitian, Increase in resident enjoyment of drinks and meals & reduction in UTIs. Decrease in resident assistance at meals by staff due to residents being more inclined to eat as they are hungry. Dietitian to educate and inform others in NMDHB of success. Feedback from food service - minimal wastage of food. |
| 1.2.3 | 1.2.3.7 | **Finding:**The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12 month period . Quality action forms are utilised at Naomi Courts and document actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, e.g. quality meeting, resident and staff meeting. Naomi Courts has two monthly quality and risk management meetings and includes progress to meeting their annual quality goals. The quality goals identified at Naomi Courts for 2012 include documented quarterly progress and evaluation. Progress is forwarded to the quality management coordinator for Bupa. The Facility Manager provides a documented weekly report to Bupa Operations Manager. The Operations Manager visits monthly and completes a report to the GM. The service completed regular progress reporting and implemented on-going corrective action plans to meet their 2012 goals; In 2012 Naomi Courts identified five goals; (i) Business Goal – Progress Steps – The manager advised that this has been a valuable goal to help the team recognise how they can achieve progression through a structured format that is evidence based. It has been a popular, successful goal and because they have had a few new people start they have decided to continue it into 2013 with good results so far; (ii) Clinical Goal – Reduce UTI rate by 20% - this was met with a final reduction by 65%, (iii) Kitchen Goal - Introduction and streamlining of the new server hatch. This started as a safety issue to decrease the flow of traffic through the kitchen. The success of the hatch is on-going as it brings the food service into the main dining room and the residents can see and be part of this. Other Quality Action forms established this year included (but not limited to); safe storage of meds to be returned to pharmacy, and assisting family to purchase correct size footwear. |

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| 1.2.4 | 1.2.4.3 | **Finding:**The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and registered nurse meeting reflect a discussion of benchmarking results. The incident/infection analysis tool and quality indicator corrective action plan is well utilised at Naomi Courts to assist with analysis and plan improvements to service delivery. Follow through of corrective actions into care plans are well documented. These are shared with staff at hand-over, tool box talks are also regularly as a result of incidents. Example: July meeting identified discussion of one resident with increased falls. Toolbox talk provided to staff to alert staff to prevention strategies. |
| 1.2.7 | 1.2.7.5 | **Finding:**The annual education programme includes two-three in-service sessions monthly. The service is also proactive around implementing toolbox training talks for staff as a result of incidents, complaints, feedback, observations, benchmarking results and internal audits (also link 1.2.3.6, 1.2.3.7 and 1.2.4.3). The following toolbox talks have been provided in 2013 to date (but not limited to); a) continence management, b) resident falls, c) positioning of residents, d) male resident shaves, e) progress notes, f) hoist use, g) transcribing, h) measuring CDs, i) post falls, and j) QI alert - med incidents. Records kept of staff that have read and signed sessions. Personal Best has been rolled out throughout the facility, and has been embraced by the staff. They have two facilitators who do the four hours of training with staff. Currently they have 77.1% staff having reached bronze level,62.9% Silver and 40% having reached gold. Naomi Courts also have three legends. Education is also provided to residents and relatives through the regular newsletters and meetings. Bupa has a comprehensive annual education schedule. There are 12 compulsory sessions per year and sessions of interest. There is a very comprehensive spreadsheet recording all attendance of staff. A big emphasis is placed on education for the team. Where they identify a weakness in their knowledge base, the education coordinator will source a speaker to upskill them. Overall attendance is very strong at Naomi Courts to education sessions. This gives evidence to a genuine want to learn in the team. |

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The Code of Rights (the Code) is clearly visible. A Code of Rights Policy is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and COR competency questionnaires. Interviews with five caregivers across all morning and afternoon shifts showed an understanding of the key principles of the code of rights. Training provided April 13 (15 attended). A Code of rights knowledge questionnaire was also completed by staff as part of the internal audit schedule Jun 13 (100%)

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. Information is also given to next of kin or EPOA to read and discuss. On entry to the service, the manager/clinical manager discusses the information pack with the family/whanau/EPOA and resident (as able). This includes the code of rights, complaints and advocacy information. The service notice board includes information on advocacy and advocacy pamphlets are available at entrance of the facility. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets.

Interviews with six relatives identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

E4.1a Six families states that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

The confidentiality and resident privacy policy states the manager is the privacy officer. During the tour of the facility respect for privacy and personal space was demonstrated. There are two double rooms in one unit. Curtains are in place and advised that the residents/relatives give permission for the shared rooms. Resident files are held in the locked nurses’ office's in each area. Interview with five caregivers could explain ways resident privacy is maintained. The Sept 12 resident satisfaction survey identified that 95% relatives stated privacy was either excellent or good.

Resident information includes Bupa vision and values. Discussions with six relatives were positive about the service in respect of considering and being responsive to meeting values and beliefs.

 D4.1a Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery. An initial care planning meeting six weeks after admission is carried out, whereby the resident/family are invited to be involved - cultural/religious would be again considered at this time.

Family members confirmed that they have adequate rights to choose within the constraints of the service (for example, meal times and meal alternatives) and that staff are obliging around choice. They stated that the smaller units make this easier. Care plans reviewed identified specific individual likes and dislikes. Caregivers from across the morning and afternoon shifts could describe examples of giving residents choice including, what time they would like to get up and go to bed, what they would like to wear and choices about food and activities. There is a question around 'choice' in the Sept 2013 resident satisfaction survey, 89% of relatives stated excellent or good.

A neglect and abuse policy (201) includes definitions and examples of abuse. Abuse and neglect training is completed annually and last delivered in May 2013 ( 23 staff attended).

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Person centred care/individuality and independence training is provided to staff annually last Feb 12 (10 attended).

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. A family/whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their family/whanau member’s stay/care

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). D20.1i The Bupa Maori health policy was first developed in consultation with kaumatua and is utilised throughout Bupa’s facilities. The CDHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. This document is also summarised for staff use as a flip chart and is available to all staff throughout the facility. Naomi Courts has an attachment to the policy that relates specifically to their area. Local Iwi and contact details of tangata whenua are identified. Special events and occasions are celebrated at Naomi Courts and this could be described by staff. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process. There are no residents at Naomi Courts that identify as Maori.

Cultural awareness training was last provided 28/3/12 (20 attended).

**Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs**

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

An initial care planning meeting six weeks after admission is carried out, whereby the family/whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete ' the map of life'. Discussions with six relatives all identified that values and beliefs were considered.

D3.1g: The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment, planning process and interviews with residents confirmed that cultural values and beliefs were considered and discussed during review of the care plan.

D4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.

**Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. The caregivers works under the direction and supervision of registered nurses.

 There is policy to guide staff practice: Gift, Gratitude’s and Benefits, Delegations of Authority. Qualified nurses meeting (monthly) includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. The code of conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. Interviews with two registered nurse described professional boundaries. Toolbox talk was provided to staff April 13 (23 attended) around the boundaries of care for two residents and allowing safe intimacy time.

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** CI

Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Naomi Courts is currently benchmarked in one area (dementia). A quality improvement programme is implemented that includes performance monitoring.

A2.2 Services are provided at Naomi Courts that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for careworkers, activity staff and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

The service is commended for achieving a continued improvement rating at a service level and organisational level through the implementation of on-going quality improvements, communication, and on-going training.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Across Bupa, four benchmarking groups are established for Rest Home, Hospital, dementia, and Psychogeriatric/Mental Health services and benchmarking data is available at Naomi Courts. The service is currently benchmarked in one area (dementia).

Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. Benchmarking data supports initiative development and Quality Indicator Corrective Action Plans have been established due to benchmarking being above the expected i.e.: raised KPI for medication incidents June 13. Action plan established which included progress and evaluation and involved toolbox talks to staff. It was identified that for the last six months Naomi Courts has only been above the benchmark 2x (both in June, one due to two medication errors and the other due to two Cat 1 incidents)

A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies.

There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants.

Standardised annual education programme, core competency assessments and orientation programmes have been implemented at Naomi Courts. D17.7c.There are implemented competencies for careworkers, activity staff and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. Competencies are completed for key nursing skills at Naomi Courts including (but not limited to); a) hoist/ manual handling, b) wound care, c) sub cut fluids, d) assessment tools, e) medications including nebulisers, BSLs/insulin, oxygen admin, syringe drivers, f) PEG feeds, catheter - female and male and g) first aid. RNs have access to external training. Two RNs are careerforce assessors and facility manager is a careerforce verifier.

A residents/relatives association was also initiated in 2009, in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group of which also involves from the exec team the CEO, GM Quality and Risk and Consultant Geriatrician currently meets every three months.

Discussions with six hospital relatives were positive about the care they receive. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). 40% staff have gold, 62.9% staff have silver and 77.1% staff have bronze.

A2.2 Services are provided at Naomi Courts that adhere to the health & disability services standards. There is an implemented quality improvement that includes performance monitoring.

D1.3 all approved service standards are adhered to.

**Finding Statement**

Bupa has robust quality and risk management systems and these are implemented at Naomi Courts supported by a number of meetings held on a regular basis including (but not limited to); quality, staff, residents, qualified nurses, IC, kitchen and health and safety. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes have been implemented at Naomi Courts. Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. A residents/relatives association was also initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Bupa provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. Bupa has introduced a "personal best" initiative whereby staff undertake a project to benefit or enhance the life of a resident(s). This is implemented at Naomi Courts - 40% staff have gold, 62.9% staff have silver and 77.1% staff have bronze. The organisation has a number of quality projects running including reducing antipsychotic drug usage (led by the Bupa Geriatrician), dementia care newsletter that includes education/information from the Bupa Director of Dementia Care and consultant psychologist and Dementia Care advisor. The newsletter also includes international best practice around dementia care. Benchmarking results are provided and reviewed at Naomi Courts. Quality Improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Naomi Courts through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. The service has introduced leadership development of qualified staff- education from HR, attendance at external education and Bupa qualified nurses education day and education session at monthly meeting. The facility manager at Naomi Courts has been involved in presenting at the Leadership training and mentoring new managers within the organisation. Naomi Courts is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and staff suggestions. QI corrective action plans are established when above the benchmark. Each action plan includes action, progress, evaluation and further recommendations. eg: med error above KPI in June 13. Recommendations were also reviewed through the qualified staff meeting, a RN completed a 'reflective practice' and the effectiveness of actions established were reviewed. Quality action forms are also established at Naomi Courts for areas that staff/management identify as requiring improvement. The following have been established (but not limited to); separating medication from meals – making meal times dedicated to the eating experience, assisting family to purchase correct size footwear, health checks of ears. Toolbox talks are routinely completed that link to benchmarking indicators at Naomi Courts. Actions are progress monitored and evaluated for effectiveness. Wine and cheese nights are established for families that include a guest speaker and families are invited to 'cooked breakfast' mornings on a Friday. The manager stated this is a good time for the management team to catch up with relatives that only visit in weekends.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Accident/incidents, category ones, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.

Two registered nurses and clinical manager interviewed stated that they record contact with family/whanau on the family/whanau contact record. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for July identified that all 20 incident forms, identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criteria is identified around "incident forms" informing family. This was last completed in March 2013 at Naomi Courts with a result of 100%. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

D16.4b All six relatives interviewed stated that they are always informed when their family members health status changes.

A residents/relatives association was initiated in 2009 in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group meets three monthly and involves members of the executive team including the chief executive officer, the general manager quality and risk and the consultant geriatrician.

In September 2009 Bupa NZ welcomed the appointment of a communications manager to the group. This person's role is to keep people informed and engaged about Bupa NZ’s strategy and the role they play, to manage how, when and what Bupa NZ communicates to keep key audiences informed.

Interpreter policy states that each facility will attach the contact details of interpreters to the policy. A list of Language Lines and Government Agencies is available. In addition there are a number of staff who are able to assist with interpreting for care delivery. A policy on contact with media is also available. Following an incident (report sited), an interpreter service was accessed for a polish relative to discuss the incident and on-going management of the resident.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. 'D11.3 The information pack is available in large print and advised that this can be read to residents.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Required consent forms (signed by resident EPOA or representative) are evident on seven out of seven files. General consent is obtained for administration of medications, laboratory tests and x-rays, the use of oxygen and suction in an emergency, medical examination by the GP, the taking of blood pressure, temperature and weight, care of catheters as required, identification photos and wound photographs, access to clinical records and a named nominated person to provide input into care planning , outings and participation in outings.

All seven of seven files evidenced a resuscitation plan for medical clinically indicated decisions in the absence of an advance directive made by the competent resident. The resuscitation plan documents there has been discussion with the family. The outcome is confirmed on the form, dated and signed by the GP. There is a GP letter on the residents file that deems the resident incompetent to make a decision on resuscitation.

Discussions with five caregivers (three morning and two afternoon shift) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Caregivers observed on the day of audit knocked in the residents door before entering the room. .

D13.1 there were seven admission agreements sighted and seven had been signed on the day of admission

D3.1.d Discussion with six family identified that the service actively involves them in decisions that affect their relatives lives.

**Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Advocacy policy (026). Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with two registered nurses described how residents are informed about advocacy and support. A resident advocate facilitates the two monthly resident meetings in the rest home and hospital.

Interviews with six relatives confirmed that they are aware of their right to access advocacy.

D4.1d; discussion with six relatives, clinical manager and facility manager identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e,: Resident files reviewed included information on residents family/whanau and chosen social networks.

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a family/whanau - participation and contact policy (476). The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping.

Visitors were observed coming and going during the audit. There is a family/whanau - participation and contact policy. The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping, folding washing. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. D3.1.e: Interviews with five caregivers and six relatives confirmed that the activity staff help residents assess the community such as go shopping. The following 'Personal Best' examples were provided in regards to accessing the community, McDonalds to get ice creams with residents, took zumba lessons with a few residents, taken residents to country & western nights, took some residents to a staff members garden to see some ducklings and movie night once a month.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The complaints procedure (065) states 'The facility manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaint management record should be completed for each complaint. A record of all complaints per month will be maintained by the facility using the complaint register. The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet'.

There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. There is a complaints register that is up to date and includes relevant information regarding the complaint (two from 2010 and 2011 were reviewed as no other written complaints have been received). Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are encouraged and actions and response are documented. Discussion with six relatives confirmed they were provided with information on complaints and complaints forms and one relative described having a concern addressed in 2011 immediately.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** CI

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Naomi Courts has set specific quality goals for 2013 including (but not limited to); a) to present a confident and knowledgeable approach about our facility to prospective customers, b) raise awareness and understanding of the progress steps, how it links in with appraisals, education etc., c) ensure best practice with IFC procedures during food service (Clinical- goal is caregiver choice).

Bupa Naomi Courts provides dementia level care for up to 50 residents. This includes 12 residents in the 12 bed Redwood unit (Male only unit), 13 residents in the 15-bed Teal unit and 16 residents in the 23 bed Maitai unit.

The organisation has commenced a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum.

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

The Manager has over 18 years’ experience managing aged care facilities and over five years in her role as manager at Naomi Courts. She is also supported by an experienced clinical manager and five registered nurses. ( the manager also provides a support role for other Bupa Care home Managers). There are job descriptions for both positions that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

ARC,D17.3di (rest home), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Bupa Naomi Courts provides dementia level care for up to 50 residents. Occupancy was 41 residents across three units.

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall.

In 2009, Bupa introduced a person centred care focus which includes six pillars. This has been embedded in service delivery at Naomi Courts.

There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Naomi Courts has set specific quality goals for 2013 including (but not limited to); a) to present a confident and knowledgeable approach about our facility to prospective customers, b) raise awareness and understanding of the progress steps, how it links in with appraisals, education etc., c) ensure best practice with IFC procedures during food service (Clinical- goal is caregiver choice).

Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs.

There is an overall Bupa business plan and risk management plan..

**Finding Statement**

Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. Facility Manager provides a documented weekly report to Bupa Operations Manager. The operations manager visits regularly and completes a report to the General Manager Care Homes. Naomi Courts is part of the Southern Bupa region which includes 11 facilities. The managers in the region teleconference weekly,. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Naomi Courts and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. Naomi Courts annual goals also link to the organisations goals and this is also reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Naomi Courts has implemented the "personal best" initiative whereby staff is encouraged to enhance the lives of residents. The Bupa Way has been launched in 2011 – the Bupa Way builds on former work that was done around the philosophy of care - Knowledgeable staff / Meaningful activities / comfortable environment etc. This is simplifying it - making it more tangible for all staff so that they can relate their actions and what they can do, to what each of our clients actually want. This was instigated from feedback from residents and relatives and includes; a) wonderful staff, b) personal touch, c) a homely place, d) partners in care, e) dementia leadership. A presentation on the 'Bupa way' has been provided to staff. Standardised Bupa assessment booklets and care plans were rolled out in 2011. The new care plan builds on the "Bupa Way", are 'person centred care focus, builds partnerships with residents and families and is a better tool for staff. Regular training has been provided to staff around person-centred care. The B-fit organisational goal is well implemented at Naomi Courts. The organisation has commenced a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Naomi Courts is very proud of the introduction of ensuring no medications are administered during the meal experience (quality initiative). This has been given high praise by their GPs and families. GPS (staff survey) 2012 results have put Naomi Courts in the top eight Bupa facilities with communication being one of their strong strengths.

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

During a temporary absence, the clinical manager covers the manager’s role. The service is supported by the Bupa Operations Manager. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

The organisation has well developed policies and procedures that are implemented at a service level and an organisation plan/processes that are structured to provide appropriate care and support for people with dementia. The service consults with the Bupa dementia leadership group, gerontology nurse specialists, physiotherapist, dietitian, hospice, and mental health for older people.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** CI

Naomi Courts has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks demonstrate a culture of quality improvements. Staff are involved in identifying quality goals that they wish to achieve for the year (link 1.2.1) Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from staff are tabled and priority for review would also be decided. These group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly the Quality and Risk Team.

Finalised versions include as appropriate feedback from the committee and other technical experts. Policies and procedures cross-reference other policies and appropriate standards/reference documents. There are terms of reference for the review committee and they follow a monthly policy review schedule.

Fortnightly release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility and clinical/facility managers identifying a brief note of which documents are included at that time. A memo is attached identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The quality and risk systems co-ordinator requests that facilities send a copy of the signed memo for filing.

Key components of the quality management system link to the two monthly quality committee through quality reports provided from departments. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across each unit and staff incidents/accidents; b) The service has linked the complaints process with its quality management system; c) There is a two monthly IC committee at Naomi Courts. Weekly reports from Bupa facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. d) Health and safety committee meets three monthly and is also an agenda item at the quality committee. Health and safety and incident/accidents, internal audits are completed. Staff and resident health & safety incidents are forwarded to Bupa H&S coordinator. Any serious incident at any facility is reported to all Bupa facilities as memo's/warnings. Annual analysis of results is completed and provided across the organisation. e) The regional restraint approval group meets six monthly.

Naomi Courts is commended for the implementation of the quality and risk management process. Monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Bupa is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to Naomi Courts via graphs and benchmarking reports.

The facility manager provides a documented weekly report to Bupa regional manager. A monthly summary of each facility within the Operations Managers region is also provided for the Ops Mgr which shows cumulative data regarding each facilities progress with key indicators – clinical indicators / H&S staff indicators etc. throughout the year. (Ops Mgrs mthly summaries).

Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are utilised at Naomi Courts and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.

D19.3:There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management (160) policy guides practice. Bupa also has a H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for 2013 with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury (these have continued over from 2012). On-going review of these objectives for Naomi Courts are documented in H&S meeting minutes.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

There is a comprehensive quality and risk management process in place. The service monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, Code of rights, weight management, H&S, accident reporting documentation, care planning, Infection control.

Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.

Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee e.g. quality, staff, and an action plan is identified. These were comprehensively addressed in meeting minutes sited.

There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Naomi Courts is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified.

The service is active in analysing data collected. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, and psychogeriatric/mental health services. Naomi Courts is currently benchmarked in one of these areas- dementia. Quality indicators are provided to the benchmarking groups. Feedback is provided to Naomi Courts via graphs and benchmarking results are discussed. CAR action plans were completed where benchmarking was above i.e. CAR completed for a Cat 1 incident June 13. Benchmarking results at Naomi Courts have remained below the benchmark for all incidents to date in 2013. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the GM.

**Finding Statement**

There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Naomi Courts is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. There are a number of improvements identified since the previous certification that have been achieved through quality improvement projects, quality goals and from analysis of quality data/internal audit results and continual roll-out of the personal best programme. A review of meetings and discussion with the management team, there continues to be a comprehensive analysis of clinical indicators, antipsychotic drug usage monitoring, and other areas such as education/competencies. Quality indicator corrective action plans have been established at Naomi Courts for indicators above the benchmark. i.e.: June 2013 - medication errors. Analysis of why an error of insulin occurred, resulted in training with RNs around best practice and change of practice. Naomi Courts has taken on board the Bupa drive for reduction in the use of anti-psychotics with their residents and on-going evaluation of effectiveness of anti-psychotics for those prescribed. From 42% in January 13 to 39% in June 13. Other improvements noted include (but not limited to); Following an education session from the Hearing Assc, they established a Quality Action around arranging regular ear checks. The outcome included contracting the local association to complete monthly ear health checks and monitoring and cleaning of hearing aids. A resident weight management initiative was implemented following an education session by Mr Tor Bogno of Sweden. He discussed the benefits of drinking (sugary drinks?) prior to meals to stimulate appetite due to the rise in blood sugar level then the fall leading to the crave for food-hunger. Naomi Courts developed a quality initiative with all staff, organised a drinks trolley with cordial juice and changed cordial time to 30 mins prior to meals. As part of their evaluation they identified significant change in weight management. Increase and stabilisation of weights. Positive feedback from dietitian, Increase in resident enjoyment of drinks and meals & reduction in UTIs. Decrease in resident assistance at meals by staff due to residents being more inclined to eat as they are hungry. Dietitian to educate and inform others in NMDHB of success. Feedback from food service - minimal wastage of food.

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

The service plans and operational structures combine to provide a comprehensive quality development and risk management system. Reports are provided to the quality meeting by key staff including; health and safety rep, infection control rep, kitchen, education, laundry, unit reports and restraint.

Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these.

Benchmarking reports are generated throughout the year to review performance over a 12 month period .

Quality action forms are utilised at Naomi Courts to document actions that have improved or enhanced a current process or system or actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, for example, quality meeting, and through newsletters.

The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the general manager, care homes.

**Finding Statement**

The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12 month period . Quality action forms are utilised at Naomi Courts and document actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, e.g. quality meeting, resident and staff meeting. Naomi Courts has two monthly quality and risk management meetings and includes progress to meeting their annual quality goals. The quality goals identified at Naomi Courts for 2012 include documented quarterly progress and evaluation. Progress is forwarded to the quality management coordinator for Bupa. The Facility Manager provides a documented weekly report to Bupa Operations Manager. The Operations Manager visits monthly and completes a report to the GM. The service completed regular progress reporting and implemented on-going corrective action plans to meet their 2012 goals; In 2012 Naomi Courts identified five goals; (i) Business Goal – Progress Steps – The manager advised that this has been a valuable goal to help the team recognise how they can achieve progression through a structured format that is evidence based. It has been a popular, successful goal and because they have had a few new people start they have decided to continue it into 2013 with good results so far; (ii) Clinical Goal – Reduce UTI rate by 20% - this was met with a final reduction by 65%, (iii) Kitchen Goal - Introduction and streamlining of the new server hatch. This started as a safety issue to decrease the flow of traffic through the kitchen. The success of the hatch is on-going as it brings the food service into the main dining room and the residents can see and be part of this. Other Quality Action forms established this year included (but not limited to); safe storage of meds to be returned to pharmacy, and assisting family to purchase correct size footwear.

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.9 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:**

 (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;

 (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The competed form is forwarded to the quality and risk team as soon as possible and definitely within 24 hours of the event (even if an investigation is on-going)". Bupa have also introduced a dedicated email address to send CAT ones to. Manned by more than one specific person – that was described as an improvement within Bupa Q+R team. A monthly Cat One summary is also sent out to care homes.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

Twenty incident forms reviewed for July identified that all demonstrated clinical follow up by a registered nurse and monitoring (such as neuro obs) having been undertaken when indicated.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 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.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and qualified staff meeting reflect a discussion of benchmarking results.

Quality Indicators - Analysis and corrective action plan policy (284) includes an objective ' corrective actions will be identified and implemented in response to increases or adverse trends in monthly resident incidents and infection rates.

**Finding Statement**

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and registered nurse meeting reflect a discussion of benchmarking results. The incident/infection analysis tool and quality indicator corrective action plan is well utilised at Naomi Courts to assist with analysis and plan improvements to service delivery. Follow through of corrective actions into care plans are well documented. These are shared with staff at hand-over, tool box talks are also regularly as a result of incidents. Example: July meeting identified discussion of one resident with increased falls. Toolbox talk provided to staff to alert staff to prevention strategies.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** CI

Register of RN and EN practising certificates is maintained at facility level. Within Bupa website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links).

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven files reviewed files (clinical manager, two registered nurses, three caregivers, and cook) and all had up to date performance appraisals. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, RN four weeks), during this period they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (five caregivers, two registered nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Interviews with the clinical manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (These align with Bupa policy and procedures).

E4.5f: Seven caregivers have completed all four dementia units, 12 caregivers have completed their foundation skills workbooks with two in the process of completing. Fifteen caregivers have commenced the careerforce four Dementia Modules.

Two senior caregivers are attending the NMDHB Walking in Another’s Shoes. The DT has completed all four units and is now completing the Core Competencies relating to Diversional Therapy. The Activities Assistant has completed two units and working on her third.

Two casual caregivers are registered nurse students.

There is an annual education schedule that is being implemented. In addition opportunistic education is provided by way of tool box talks. There is an RN training day provided through Bupa that covers clinical aspects of care - eg. Dementia, Delirium and Careplanning. There is evidence on RN staff files of attendance at the RN training day/s and external training.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality meetings.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has recently approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. At Naomi Courts, the clinical manager has completed her PDRP. There are five registered nurses in total at Naomi Courts. One RN has completed her PDRP, there is one casual RN. Two RNs are careerforce assessors for the Dementia Units and Foundations Skills Books. Two RNs are students of the Leading Bupa 2020 leadership programme.

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** CI **Risk level for PA/UA:**

Naomi Courts has a comprehensive annual education schedule which is adhered to and records of attendance for all staff are kept. There are at least four scheduled training sessions a month. Several education sessions are compulsory and all staff are expected to attend. Education topics and information is also displayed on the communication board for staff that are not able to attend to read. Toolbox talks held on a regular basis and staff been encouraged to participate. Compulsory education is repeated throughout the year at different times, to give all staff the opportunity to attend

**Finding Statement**

The annual education programme includes two-three in-service sessions monthly. The service is also proactive around implementing toolbox training talks for staff as a result of incidents, complaints, feedback, observations, benchmarking results and internal audits (also link 1.2.3.6, 1.2.3.7 and 1.2.4.3). The following toolbox talks have been provided in 2013 to date (but not limited to); a) continence management, b) resident falls, c) positioning of residents, d) male resident shaves, e) progress notes, f) hoist use, g) transcribing, h) measuring CDs, i) post falls, and j) QI alert - med incidents. Records kept of staff that have read and signed sessions. Personal Best has been rolled out throughout the facility, and has been embraced by the staff. They have two facilitators who do the four hours of training with staff. Currently they have 77.1% staff having reached bronze level,62.9% Silver and 40% having reached gold. Naomi Courts also have three legends. Education is also provided to residents and relatives through the regular newsletters and meetings. Bupa has a comprehensive annual education schedule. There are 12 compulsory sessions per year and sessions of interest. There is a very comprehensive spreadsheet recording all attendance of staff. A big emphasis is placed on education for the team. Where they identify a weakness in their knowledge base, the education coordinator will source a speaker to upskill them. Overall attendance is very strong at Naomi Courts to education sessions. This gives evidence to a genuine want to learn in the team.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.

There is a Facility Manager (RN) Mon - Fri and a Clinical Manager (RN) Mon - Fri and a registered nurse rostered across seven days on a morning and an afternoon shift.

Interviews with six relatives all confirmed that staffing numbers were good.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure cabinet or secure storage for unused files.

Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing.

Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. There is also an allied health services assessment form with care requirements.

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

**STANDARD 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has a well-developed assessment process and resident’s needs are assessed prior to entry. The service has a comprehensive admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and or family/whānau are provided with information in relation to the service. The RN's interviewed are knowledgeable in the admission process and confirm the level of care is approved prior to entry.

Information gathered at admission is retained in resident’s records. Six family members interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks. There is an admission policy, a resident admission procedure and checklist. There is a documented procedure for respite resident admission.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

E3.1 Seven resident files were reviewed and all includes a needs assessment as requiring specialist dementia care

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

**Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

A registered nurse undertakes the assessments on admission in the seven resident files sampled, with the initial resident assessment booklet completed within 24 hours of admission. The care plan summary policy states that the care plan summary is completed by the registered nurse within one week of admission. It is a summarised account of the cares a resident needs and will be used by caregivers to ensure care delivery is in line with the care plan. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change). A resident needs data collection form is commenced for staff input. Within three weeks the long term care plan is developed in seven of seven files sampled.

Medical assessments are completed on admission by the GP in seven of seven files sampled and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers, the GP, the Diversional Therapist (DT) and any other relevant person.

Activity assessments and the activities sections care plans have been completed by a diversional therapist.

Six family members interviewed state they are involved in their relatives care plan and evaluation. Resident files included family contact records which were completed and up to date in seven resident files sampled.

D16.2, 3, 4: The seven files reviewed ,identified that in all seven files an assessment was completed within 24 hours and all seven files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a RN and amended when current health changes. All seven care plans evidenced written MDT reviews at least six monthly.

D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly. The GP interviewed visits the facility every six weeks to carry out resident three monthly reviews that are due. He has input into the MDT reviews. If the GP has any medical concerns he will meet or phone the families to discuss his concerns. The GP is available for urgent visits and the RN's promptly report any resident concerns by phone or ISBAR communication faxes. There is an afterhours help line and access to a GP at the Nelson hospital ED. The GP states the RNs have good clinical judgement and he receives positive and complimentary feedback from the residents families.

A range of assessment tools where completed in resident assessment booklet files on admission and completed at least six monthly including (but not limited to); a) FRAT falls risk assessment b) pressure area risk assessment (Braden scale ), c) continence assessment , d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and dietary requirements g) pain assessment/Abbey pain scale h) behavioural assessment, and wound assessment (where appropriate)

The community mental health liaison nurse visits weekly and meets with the Clinical Manager to review/follow-up residents currently under the mental health service and provide advice/management on any new resident concerns.

A community dietitian has been contracted to meet with the Clinical Manager and review all residents dietary profiles and requirements every six months and is available for advice as needed.

The podiatrist visits six weekly and attends to all residents foot care.

The BUPA physiotherapist reviews residents six monthly and provides moving and manual handling education to the staff. The physio is available as required. All seven files have at least an initial physiotherapy assessment with on-going assessments as necessary.

Seven files identified integration of allied health and a team approach.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. The RN's also meet with the Clinical Manager on the morning and afternoon shift during the week. An RN diary is in use. RN's state the caregivers are prompt to report any residents concerns and changes in health status.

Clinical staff have attended relevant education in dementia care, observations and reporting, falls prevention, clinical assessment. In addition "tool box talks" include positioning of residents, male resident shaves and hip protectors. An internal care and hygiene audit conducted March-13 scored 97.7%.

Seven dementia care resident files were sampled.

Tracer Methodology: dementia care resident.

  *XXXXXX This information has been deleted as it is specific to the health care of a resident*.

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Naomi Courts has implemented the Bupa assessment booklets and lifestyle templates for all residents. The assessment booklet includes input from team members. The assessment booklet provides very in-depth assessment tools including; falls, Braden, skin, mini nutritional, continence, pain, dependency and activities. The falls assessment section also includes additional risk factors, for example; vision, mobility, behaviours, environment and continence.

Risk assessment tools and monitoring forms are reviewed at least six monthly and are used to effectively assess level of risk and required support for residents including (but not limited to); Braden scale, pressure area risk assessment, FRAT falls assessment, pain assessment, MNA, incontinence assessment, behaviour assessment, , pain assessment, skin assessment, dependency rating and wound assessment (where appropriate).

The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, cultural , activities preferences, food and nutrition information.

Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by the RN. Assessments and support plans are comprehensive and include input from allied health. Notes by GP and allied health professionals are evident in residents files, significant events. A family/whanau contact list is kept of communication with families and notes sighted include discussions on incidents, behaviour, appointments, health changes, referrals, medications, care plans and MDT reviews. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met.

E4.2; Seven resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements over a 24 hour period.

E4,2a Challenging behaviours assessments are completed

**Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Service delivery plans (lifestyle care plans) are comprehensive and demonstrate service integration and demonstrate input from allied health.

The care summary is developed from the assessment information and guides the staff in the safe delivery of care for the residents. The family sign the front page of the care plan to acknowledge their approval and participation in the process. GP medical notes and allied health professionals progress notes are maintained and are kept in the residents integrated file.

Initial care plan is completed on admission and there are initial care planning minutes evident in the resident files sampled that confirm MDT and family involvement. The RN completes the long-term care plan within three weeks with staff, family, allied health and GP consultation. There is a long term care plan that includes; a) hygiene, b) medical, c) skin and pressure area care, d) bladder and bowels, e) mobility, f) food and fluids, g) rest and sleep, h) communication, i) emotional well-being, j) mood and behaviour k) spirituality, l) religion and culture, and m) activities

Plans are well described and are reflected in the progress notes. All seven residents' care plans reviewed on the day of the audit provide evidence of individualised support and intervention required.

 A Map of Life called "My Day, My Way" is developed for each resident which covers their individual needs, values, beliefs, culture, social interactions, activities, personal care and grooming preferences and other aspects of their life that is important to them in their day, for example friends, family, pets etc. A dementia specific 24 hour activity plan is evident in each of the resident files sampled. The plan describes how the resident expresses themselves, what may trigger incidents, activities that make the resident feel calm and what activities the resident can be involved in over a 24 hour period.

Short term care plans are used for short term needs with written documentation that includes a need, intervention, evaluation and signature. There are pre-printed short term care plans for falls, weight loss, UTI, possible fungal infection, chest infection, scabies which are individualised as required.

Six families interviewed confirm care delivery and support by staff is consistent with their expectations. All needs identified in the assessment process were included in the care plans.

E4.3 Seven of seven resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; Seven resident files reviewed identified that family were involved.

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents' lifestyle care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or nursing specialist consultation. The RN records any resident assessment, significant events, GP visits, changes in resident status in the resident progress notes. Registered nurses stated that when something is needed that is not available, management provide this promptly.

All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. The care being provided is consistent with the needs of residents, this is evidenced by discussions with two RNs, five caregivers six families interviewed, the clinical manager and facility manager. There is a short-term care plan that is used for acute or short-term changes in health status.

Wound initial assessment and plan and wound management plans are in place for four residents; one pressure area of toe, two wounds (upper arm, lower leg) and two skin tears. Regular evaluations are completed by the RN. Specialist wound advice is available as needed and this could be described by the two RN's interviewed. Wound care education has been provided in May-13.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services have been provided in June-13

The Clinical Manager and Registered Nurses described the referral process and related form should they require assistance from a nursing specialists allied health professionals. The dietitian, physiotherapist, podiatrist and community mental health liaison nurse visit regularly.

Ear health checks are carried out regularly and residents are referred to the ear specialist for removal of wax as necessary. The Ear health nurse checks hearing aids monthly.

A resident clinical contact record of significant events, blood tests, GP and allied health visits, hospital transfer, referrals is maintained and kept in the resident record.

Residents with high falls risk as identified through the assessment process have appropriate intervention and management plans in place that are evaluated at least six monthly or earlier if required. Hip protectors and sensor mats are used. Staff are required to check all sensor mats at the beginning and end of each shift to ensure they are functioning.

All residents have a pain assessment on admission. There are two pain assessment tools available to use (verbalising and non-verbalising - Abbey pain scale) dependent on the residents cognitive ability. Pain monitoring tools are evident in the medications folder.

Residents are weighed monthly and entered into a computer data base which "flags" residents at risk. RN's commence a weight loss short term care plan including a daily nutritional record and an increase in weighing frequency. Regular evaluations identify further intervention such as dietitian referral and GP consult. An internal audit on weight management in Feb-13 scored 97.5%.

There are monitoring forms available for use including behavioural, pain, nutritional, continence diary, bowel records, weight, blood pressure, neurological observations, diabetes and restraint/enabler monitoring forms.

During the tour of facility it was noted that all staff treated residents with respect and dignity. Families are able to confirm this observation.

Six families interviewed and the GP are complimentary of care received at the facility.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a qualified Occupational therapist (OT) and an activity assistant employed to develop and implement the activity programme for residents within the three dementia care units. The OT attends the regional two monthly DT meetings and undertakes any relevant training offered. The OT meets with the resident/family within the first two weeks to develop an activity plan. The DT and RN complete the first part of the resident care plan that includes activities and social interactions. "My Day, my way" activity plan provides a 24 hour period of activities individualised for the resident. There are recreational progress notes in the resident’s file that the OT and activity assistant completes for each resident every month. Each resident has a 'map of life'. The resident/family/whanau as appropriate is involved in the development of the activity plan. The OT is involved in the MDT review six monthly. A monthly planner is posted on the notice board so that families and staff are aware of the upcoming activities for the residents. A large print colourful weekly events flyer highlights the week’s events. Families are encouraged to join in with the events, outings and entertainment. An invitation was noted for families and friends to join staff at an upcoming wine and cheese evening with a guest speaker. There is a wide range of activities offered that reflect the resident needs. Group activities include sing-a-longs, reminiscing, quizzes, newspaper reading, walks, yoga, bingo, happy hour, watching the older programmes on TV and DVD afternoons. Entertainers include the ukulele ladies, line dancers and singing groups. There are two volunteers who assist residents with gardening and one comes in at the weekend to chat with residents and carry out nail manicures. Redwood and Maitai have a large shared lounge for group activities. A smaller lounge is available for more individual activities. Entertainment and activities are rotated around the units and all residents are encouraged to attend if they wish. There is individual one on one activities including hand and nail care, walks and chats. Outings are arranged and car transport is available. The activities team have current first aid certificates. On the day of audit residents in Teal enjoyed a singing and percussion session. Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia units which are conducted by care staff out of normal hours

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when the care plan review/evaluated.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Long term plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least three monthly reviews by the medical practitioner. More frequent reviews occur for residents where there has been a change in health status. There are short term care plans to focus on acute and short-term issues. Short term care plans are evaluated regularly and are either resolved or added to the long term care plan as an on-going problem. Changes to the long term care plan are made as required and at the six monthly review if required. There are six monthly MDT reviews which includes input from RN's, caregivers, DT, GP, family and any other relevant health professionals that have been involved in the care of the resident. There is evidence of evaluation of wound management plans. Care plans and activity plans are resident focused (My Day , My Way) and evaluated six monthly.

D16.4a Care plans are evaluated six monthly, more frequently when clinically indicated

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)**

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Referral to other health and disability services is evident in seven of seven resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; needs assessment team, psychiatrist consultant for the older person, podiatry, dietitian, ear health, otolaryngology, ultrasound, haematologist, physiotherapy, community mental health liaison nurse. The families are informed of any referrals and are advised of any options available as evidenced in the family/whanau contact sheet.

D16.4c; the service does not have any residents currently awaiting reassessment for a higher level of care.

D 20.1 discussions with registered nurses identified that the service has access to nurse specialists such as continence, wound, district nurses, hospice and mental health service.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident’s file. This was sighted in one resident files (from the rest home) where the resident had been transferred to hospital acutely following a fall. All relevant information is documented and communicated to the receiving health provider or service. A transfer form, GP notes, progress notes, medication chart and any other relevant documentation accompanies residents to receiving facilities. If family are unable be with the resident on transfer to hospital a staff member accompanies the resident. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made

**Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Medication Management policies include a) Prescribing, b) Medication administration c) Pharmacy Errors, d) Delivery and receipt, e) Medication review, f) Storage, g) PRN doses, h) Alternative therapies, i) Outdated stock/medications no longer required, j) Changes to medication, k) Medication reconciliation, l) Refusal of medications, m) Controlled drugs. Medications are managed appropriately in line with accepted guidelines. The regular medications are supplied in robotic rolls and checked on delivery by the RN. Any discrepancies are fed back to the supplying pharmacy. Medication audits are completed six monthly. PRN medications are in medico packs. The medications are stored in locked trolleys for each of the units. All eye drops are dated on opening. The GTN spray and Glucagon injection are within the expiry dates. The medication fridges temperatures are checked weekly. Controlled drugs are stored in a locked safe in the treatment room and two medication competent persons must sign controlled drugs out. There are weekly controlled drug checks sighted in the controlled drug register. Registered nurses or senior caregivers administer medications who have passed their competency administration assessments annually. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off. Medication education has been provided in May-13. The medication folders include a list of specimen signatures for medication competent staff. The medication folder also contains approved abbreviations, pharmacy information and description of medications and GP specimen signatures.

Medication charts have photo ID’s and allergies noted. Alternative remedies (rescue remedy) are charted and the pharmacy is made aware. There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on the medication signing sheets. All medications are signed for correctly and there are no gaps. One resident in hospital has an "H" coded in the medication signing sheet.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. The prescribing of regular medications meet legislative requirements. The PRN medications do not prescribe a reason/indication for use. The clinical manager has raised a corrective action around the prescribing of PRN medication and a 'letter (sighted) has been sent to the GP's. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies. Each resident medication chart has instructions on how the resident likes to take their medication such as crushed or with food. Residents on anti-psychotic medications have a monitoring plan with their medication chart. Residents have their medications reviewed weekly on the commencement of new anti-psychotic medication and monthly for on-going medications. The aim is for the GP to reduce the antipsychotic medication by 25% after each review if appropriate.

D16.5.e.i.2; 14 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

**Criterion 1.3.12.1 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The main kitchen is located directly off the large main dining room which is shared by Redwood and Maitai residents. The kitchen is keypad locked and meals are served from the servery. Meals are delivered by trolley to Teal unit and are ready to serve. Teal has a small tea making area which is closed off by a roller door when not in use. There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety. The main cook is employed from 6am - 1pm daily and is supported by a morning and afternoon kitchen hand. The cook has received training in food safety and hygiene and holds NZQA units 167 and 168. The reliever cook and kitchen hands have also received appropriate training. Each resident has a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed at least six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook. Special diets being catered for include soft diets and puree diets. The cook is informed of any weight loss concerns and interventions implemented for example, one resident with weight loss will only eat chicken and the cook accommodates the residents need. Religious and cultural preferences are accommodated if required . There is a six weekly menu that has been developed by the company dietitian and is followed in Bupa facilities nationwide. The menu covers the four seasons and allows for flexibility to meet the residents individual needs. Monthly teleconferences are held with the chefs/cooks employed in each home. Annual education days are also held for all the cooks/chefs. All meals and baking is done on site. The kitchen is well equipped with combi and electric ovens. There is a good work flow in the kitchen with separate storage, food preparation, baking and cooking, serving and dishwashing areas. The fridges and two freezer temperatures are monitored daily. The hot foods are monitored daily. All recordings sighted show temperatures are within the correct range. There is a kitchen hand duties and cleaning schedule and night duty mop the kitchen and dining room floors. Food deliveries arrive through the back door entrance. Pantry stock is rotated on delivery. There is at least three days of food held in the event of an emergency. A barbeque is available. Chemicals are supplied by Johnson Diversey who conduct internal audits on the effectiveness of the chemicals and check the dishwasher is functioning according to required standards. All chemicals in the kitchen are stored safely. Kitchen staff are observed wearing correct protective wear, hats, aprons and gloves. Fly screens and a fly "zapper"are in place. The cook attends the health and safety/infection control/quality meetings. Feedback on the service is received through meetings, internal audits, direct feedback from residents (where able) and families and staff. The service has recently commenced resident and family cooked breakfast on Friday's which has been well received. The service has implemented a number resident-focused initiatives around the food service and weight management, which have identified a number of positive outcomes (link 1.2.3.6)

E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours

D19.2 staff have been trained in safe food handling.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Chemical/substance safety policy (048). There are policies on the following:- waste disposal policy. - medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics. General waste is removed from the property twice weekly . Procedure for disposal of sharps containers. Sharps containers are available and meet the hazardous substances regulations for containers. Two fire extinguishers are available in the garage.

The maintenance officer oversees the chemical storage and distribution of chemicals to the housekeeping, laundry and kitchen areas. Johnson Diversey are the chemical suppliers. All chemicals are clearly labelled with manufacturers labels. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Safety data sheets are available. There is a chemical spills kit readily accessible. Hazardous substances such as petrol and spraying chemicals are in locked cupboards in the garage.

Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled.

Management of waste and hazardous substances is covered during orientation of new staff and an education conducted in Feb around chemical safety. An internal audit on waste management and chemical safety was completed in March-13 with 96.6% compliance Corrective actions have been implemented and signed off.

**Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The building holds a current building warrant of fitness. Fire protection inspection services are responsible for the maintenance of fire equipment.

A visual inspection of the facility and environment post-earthquake (21/7/13) was carried out and there is no reported structural damage. The main entrance has an external and internal secure access. There are three secure dementia wings. Redwood is a 12 bed male only wing. Teal (15 bed) and Maitai (23 beds) are both mixed gender wings. Staff amenities and administration offices are located upstairs. There is a maintenance officer who works a total of 7.5 hours per day Monday to Friday and available on call for urgent matters. He conducts a daily round of all areas and checks the maintenance books in each office for any maintenance requests. There are planned maintenance schedules for monthly (wheelchairs, nurse call system, external lights), two monthly (air filters, air conditioners), three monthly (sanitizers), six monthly (trolleys) and annual (external) maintenance checks. Hot water temperature monitoring is conducted monthly and corrective action taken as required. Monthly monitoring forms sighted. Electrical equipment is checked annually. All medical equipment was calibrated by BV medical and the sling hoist, electric bed and weighing scales were checked and serviced at this time. The fish aquariums are maintained by contractors.

The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required.

The furnishing and fixtures are appropriate to the consumer room. Seating is arranged to allow group and individual activities to occur. A family room is available with tea making facilities. A hair salon is available.

The external areas are well maintained and gardens are attractive. There is easy access to secure and safe walking paths from each unit. Outdoor seating, shade and a gazebo is available. There is wheelchair access to all areas. A volunteer assists residents in maintaining the raised flower and vegetable gardens.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; e: The following equipment is available, pressure relieving mattresses and cushions, shower chairs, walking frame, commode chairs, walk on/wheel on weighing scales, sling hoist. The Clinical Manager, two RN's and five caregivers report there are no problems accessing equipment and resources when required.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The facility has three secure dementia units. All rooms have a hand basin. There are two ladies rooms that share an ensuite. There are adequate showers and toilets throughout the facility. Communal toilets and bathrooms have appropriate signage and privacy curtains installed. Two RN's and five caregivers interviewed described how a residents privacy and dignity is maintained when attending to the residents personal hygiene requirements.

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The rooms are spacious and it can be demonstrated that wheel chairs, hoist and the like can be manoeuvred around the bed and personal space. Residents were seen to freely mobilise within their bedrooms with mobility aids as required. Standard beds are provided and there is one electric bed available for use as required. Five caregivers (three morning and two afternoon shifts) report that rooms have sufficient rooms to allow cares to take place. Six family members are content with their relatives bedroom space and can personalise their rooms. The bedroom doors are named and also have photos on the door to assist the resident to recognize their room.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

All lounge/dining rooms within the units are accessible and accommodate suitable furnishings and seating to meet the resident’s needs. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. Activities occur throughout the facility. Teal unit has its own open plan dining room and lounge. Maitai and Redwood share the dining and lounge areas during the day.

 D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. Laundry services audits are completed 2 x a year and last done June-13 (98.12.%). An environmental hygiene - cleaning audit was last completed in June-13 (100%). Corrective actions required are followed through the quality/risk management and staff meetings. The main laundry room is located outside of the secure area. There is a smaller laundry room within the Teal unit. This laundry operates during the night and while located within a resident area the laundry was operating at the time of audit and there was no noise heard in the bedroom. The cleaners trolley is stored in the external garage when not in use. Chemicals are stored in locked rooms. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. One sluice room has a sanitizer. These staff only areas are kept locked with chemicals stored safely. Laundry and cleaning staff have attended chemical safety training in Feb-13 and infection control in service as offered.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety is provided annually. Fire evacuations are held six monthly. There is a staff member on 24/7 with current first aid certs.

There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents’ details. There is an approved evacuation plan.

The facility is well prepared for civil emergencies and has emergency lighting and BBQ’s. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits.

Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept.

There is a store cupboard of supplies necessary to manage a pandemic.

The call bell system is available in all areas. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were overall answered in a timely manner.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D 🞏 SI 🞏 STI 🞏 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The facility has overhead heating and heat pumps in communal areas where required. Facility temperatures are monitored to maintain an air temperature of 19 degrees Celsius. Rooms are well ventilated and light. There is plenty of natural light in resident’s rooms

Six family members interviewed stated the temperature of the facility was comfortable.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

E4.4a the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour

Restraint policy (251) states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated".

There is a regional restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service is restraint-free and staff complete competencies in relation to the restraint-free philosophy.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**STANDARD 3.1 Infection control management**

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The infection control committee includes a cross section of staff all areas of the service.

The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the GP's, southern community lab, the infection control and public health departments at the local DHB. There are two monthly infection control meetings. The quality meetings/staff meetings and RN meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff.

Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

A norovirus outbreak 22 Jan - 28 Jan 13 (involving 18 residents and 14 staff) included a special report, special management meeting, notified all family, GPs, and toolbox talks provided to staff.

**Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings occur two monthly and follow the quality committee meeting.

The infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the facility manager, the clinical manager (IC coordinator), registered nurse and other staff. The facility also has access to an infection control nurse, public health, SCL, G.P's and expertise within the organisation.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.

There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.

Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.

External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator, the infection control committee and expertise from the governing body.

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has attended Bug control training. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, and Bug Control for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand washing and standard precautions. Training on infection control was held on May 13 (28 attended), toolbox talk Feb 13. All training is mandated by Bupa and evaluated by staff who attend. Records of the evaluations were sighted.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of family education around influenza and outbreaks.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager’s report on quality indicators.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Infections remain low in 2013 with only two recordings of being above the benchmark (March - two wound infections and Jan - gastric, related to outbreak). Quality indicator - corrective action plans were established.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**