

Bupa Care Services NZ Limited - Remuera Care Home

Current Status: 22 September 2014

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

General overview

Remuera Care Home is owned and operated by the Bupa group. The service is certified to provide rest home level care for up to 40 residents. On the day of the audit there were 33 privately funded rest home level residents living at the facility. The premises are currently undergoing renovation as vacancies permit.

Since the previous audit there have been new appointments to both the facility/village manager role and the clinical manager role. The facility/village manager commenced in January 2014 and the clinical manager commenced in July 2014. Both managers were internal appointments within the Bupa group and both are practising registered nurses.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who require rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to the facility.

There have been a number of improvements made since the previous audit including internal renovations and improvements to the entrance area. The service has addressed three of the four shortfalls from their previous certification around corrective action planning, maintaining up to date staff competencies, and medicine management. Further improvements continue to be required around tap hot water temperatures in resident rooms.

This audit identified four improvements required around the documentation of care, the documentation of PRN (as required) medicines, the need to lock the nurse's station when not in use, and the need to record the hot water zip on the hazard register.

Audit Summary as at 22 September 2014

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

Indicator	Description	Definition
	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

Consumer Rights as at 22 September 2014

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

Organisational Management as at 22 September 2014

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

Continuum of Service Delivery as at 22 September 2014

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

Safe and Appropriate Environment as at 22 September 2014

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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Restraint Minimisation and Safe Practice as at 22 September 2014

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.
---	--	--

Infection Prevention and Control as at 22 September 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

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

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Bupa Care Services NZ Limited		
Certificate name:	Bupa Care Services NZ Limited - Remuera Care Home		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Remuera Care Home		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 22 September 2014	End date: 23 September 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			33

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	15.5	Hours off site	8
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	15.5	Total audit hours off site	10	Total audit hours	25.5
Number of residents interviewed	6	Number of staff interviewed	6	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	28	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Monday, 20 October 2014

Executive Summary of Audit

General Overview

Remuera Care Home is owned and operated by the Bupa group. The service is certified to provide rest home level care for up to 40 residents. On the day of the audit there were 33 privately funded rest home level residents living at the facility. The premises are currently undergoing renovation as vacancies permit.

Since the previous audit there have been new appointments to both the facility/village manager role and the clinical manager role. The facility/village manager commenced in January 2014 and the clinical manager commenced in July 2014. Both managers were internal appointments within the Bupa group and both are practising registered nurses.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who require rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to the facility.

There have been a number of improvements made since the previous audit including internal renovations and improvements to the entrance area. The service has addressed three of the four shortfalls from their previous certification around corrective action planning, maintaining up to date staff competencies, and medicine management. Further improvements continue to be required around tap hot water temperatures in resident rooms.

This audit identified four improvements required around the documentation of care, the documentation of PRN (as required) medicines, the need to lock the nurse's station when not in use, and including the need to record the hot water zip on the hazard register.

Outcome 1.1: Consumer Rights

The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Policies and associated procedures are implemented to support resident rights such as the right to be fully informed and to make an informed choices and the right to complain. Information about the Code is readily available to residents and families. Complaints processes are implemented. Residents and family interviewed verified that staff contact them if there is a change in the health status of their relative and all spoke very positively about the new management and the standard of care provided.

Outcome 1.2: Organisational Management

Remuera Care Home is governed by the Bupa Group. The facility/village manager and the clinical manager are new appointees to their roles. They are supported by the operations manager who visits the premises at least once a month. Bupa has a business plan in place and the service operates a quality plan with goals for the calendar year. The service operates an established quality and risk management system that is integrated in planning and overseen by the quality and risk team at head office and local management. An annual resident and/or relative satisfaction survey is completed and there are regular resident and relative meetings. Adverse event reporting occurs and staff communicate events to relatives where appropriate. Quality and risk performance is reported at facility level at meetings and displayed on staff notice boards.

Key quality indicators are benchmarked with other Bupa operated facilities operating rest home services throughout New Zealand and results are fed back to the facility. The systems for quality and risk management are continually being reviewed at both an organisational level and at Remuera Care Home. There are established human resources policies and procedures in place. New staff are provided with a comprehensive orientation programme. There is an 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 appropriate for the level of service provided and exceed contract requirements due to the layout of the premises. Management monitor staff competencies to ensure staff meet requirements. The two previous shortfalls which related to corrective actions not being implemented and signed off and staff competencies being overdue have been addressed.

Outcome 1.3: Continuum of Service Delivery

The facility has a comprehensive range of service policies, associated procedures and forms to guide staff. Service information is made available to consumers and their family prior to entry. Registered nurses are responsible for each stage of service provision. Service provision meets required timeframes. There are established systems to assess, plan and evaluate care needs of residents. Residents are reviewed on a regular basis and families participate as appropriate. The medicine management system follows policy.

The activities programme is facilitated by one activities co-ordinator. Residents can participate in a variety of options and activities are held in various areas within the facility. Community activities are encouraged. Van outings are arranged on a regular basis.

The majority of food is prepared and cooked on site. Meals are cooked according to the Bupa nationwide dietitian approved menu plan. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented. Consumers and relatives expressed satisfaction with the menu.

The previous shortfall related to medicine management has been addressed. This audit identified two improvements which relates to the need to document care as outlined in policy and the need to ensure as needed (ie, PRN) medicine instructions are fully recorded.

Outcome 1.4: Safe and Appropriate Environment

The building has a current building warrant of fitness. Further improvements continue to be required around hot water temperatures in taps within residents' rooms. This audit identified that the hot water zip in the upstairs kitchenette is a hazard that needs addressing and the nurses station on the ground floor requires a lock, as it contains resident information and a refrigerator which is used for the storage of medicines.

Outcome 2: Restraint Minimisation and Safe Practice

The service is restraint and enabler free. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The clinical

manager, who is a registered nurse, fulfils the role of infection prevention and control co-ordinator. He is responsible for coordinating the surveillance aspects of the programme and is supported by the facility/village manager and the Bupa quality and risk team.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	3	0	0	0
Criteria	0	38	0	3	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	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.	PA Low	Documentation of the accident that occurred on the first day of audit was not consistent with current accepted good practice or Bupa policies.	Ensure documentation occurs in a timely manner consistent with accepted good practice and policies.	30

HDS(C)S.2008	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.	PA Low			
HDS(C)S.2008	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.	PA Low	Two of ten medicines charts reviewed showed that the prescriber had not recorded specific target symptoms for the administration of PRN (ie, as needed) medicines.	Ensure prescriber orders for all PRN medicines include target symptoms.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	The hot water temperatures at the taps in residents' rooms continue to be above 45 degrees Celsius and the hot water cylinder in the upstairs kitchenette is a burn hazard. The nurses' station located on ground floor needs to be able to be locked when not in use to ensure clinical information and refrigerated medicines are stored safely.	Ensure the hot water temperatures at the taps in residents rooms are maintained at 45 degrees Celsius or below and ensure that the hot water cylinder in the upstairs kitchenette does not present a burn hazard. Ensure the nurses' station located on ground floor is able to be locked when not in use.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: 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 1.1.9: Communication (HDS(C)S.2008:1.1.9)

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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

The service provides an environment which enables effective communication with residents. This includes full information at entry and open disclosure. Management contact relatives and discuss matters in an open manner consistent with the open disclosure policy. The accident/incident forms have a section to indicate if family/whanau have been informed (or not) and the name of the person informed. Staff record contacts with family/whanau on the family/whanau contact record.

All seven of seven accident/incident forms reviewed for August 2014 identified that family were notified when the incident occurred. Relatives are notified as soon as staff become aware that a resident's health has changed significantly (confirmed in discussions with the clinical manager and two of two relatives). Residents are orientated to the service on admission. Informed consent processes are in place. Residents have access to interpreter services which includes access to the Blind Foundation and the Hearing Association.

Each resident or their nominated representative is provided with an admission agreement (which is a Bupa template document) and a copy is stored onsite in the administration office. The admission agreement references exclusions from the service. The information pack is easy to read and if needed the information can be read to residents and is available in large print. All residents are private payers (ie, non-subsidised). Residents are advised in writing of the process to become a subsidised resident should they wish to do so. People who have been assessed by the needs assessment agency and are looking for long term care following assessment are redirected to other facilities in the area. 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 for their information. Residents and family are informed in the Agreement prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. On-call emergency services are available and these costs are typically met by the individual resident. In times of emergency when relatives are not available the facility will transport residents to their general practitioner.

The internal audit programme includes an audit of compliance with consumer rights (last internal audit was conducted 29 June 2014 with 100 percent compliance).

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

Attainment and Risk: FA
Evidence: There is a documented complaints policy and associated procedure and template letters that comply with Right 10 of the Code. The complaints process is easily accessible to residents and family members (confirmed in discussions with six of six residents, two of two families and observation onsite). Complaints are logged in a complaints register, which is maintained in both hard and soft copy. There have been no complaints received year to date. There was one consumer complaint received in 2013

regarding the cleanliness of a bathroom. The register is maintained in monthly format at the facility. It is up-to-date and includes all complaints, dates, and actions taken. Complaints are managed locally with head office oversight to ensure all complaints are managed appropriately. All allegations are actively investigated by the facility/village manager. Management have access to a number of template response letters to ensure documentation complies with the Code. There are six monthly external compliance audits to ensure on-going compliance to the documented complaints process (last internal audit of client rights was conducted in June 2014 which achieved 100 percent compliance). Staff are aware of the complaints policy and can correctly articulate their responsibilities (confirmed in discussion with the facility/village manager, the clinical manager and two of two caregivers).

Copies of complaints were sighted (both hard copy complaints and entries on the complaint register). All complaints received since January 2013 were reviewed. The complaint contained documentation of the investigation, corrective action, and correspondence with the complainant. Education on the Code was last provided on 26 March 2014 attended by eight staff.

The complaints process is provided to resident/relatives at entry to the service and is also prominent around the facility on noticeboards. Discussion with six of six residents and two of two family members confirmed they were provided with information on complaints management and were able to access forms if needed.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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 (HDS(C)S.2008:1.2.1)

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

Attainment and Risk: FA

Evidence:

Private rest home services are provided for up to 40 residents. At the time of the audit, there were 33 rest home level residents living at the premises. The service does not have an ARC contract with the DHB.

Remuera Care Home is owned and operated by Bupa Care Services NZ (Bupa). Bupa's head office is based in Auckland. There is a three year strategic plan in place covering 2012 to 2015 (sighted), which is available on the Intranet. The plan identifies the overall objectives of the business. There is an overall Bupa business plan and risk management plan in place and an annual quality plan in place for Remuera Care Home which includes specific quality goals.

The service is managed by the facility/village manager who is a registered nurse (RN). She has been in the role since January 2014. She has been working in aged care since 2002 and with Bupa for over two years. Prior to this appointment was employed as a facility manager in another Bupa facility and her appointment was an internal transfer. She is supported by a clinical manager who is new to the position although he has worked at the facility prior to his appointment. He has been employed by Bupa for over three years. Support is also provided by the operations manager who visits the facility at least once a month.

The facility/village manager has the authority, accountability, and responsibility for the provision of services (confirmed in review of the job description for the position and in discussion with her as her employment records are held at head office). She is supported by a full-time clinical manager who is a recent appointment. He commenced in the role in July 2014 (confirmed in review of his employment records). Both managers are supported by the Bupa executive team and the operations manager (who was present at the end of the audit).

Bupa has a robust quality and risk management system in place which is standardised and implemented across its facilities. The system is monitored closely by head office staff. The service has policies and procedures and associated implementation systems to provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001.

The quality monitoring programme includes six monthly compliance audits on a rolling programme by the organisation's management, which is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Non-compliance for these audits below predetermined levels of compliance will result in corrective action plans being developed which in turn are monitored by head office staff. There are sound financial management systems in place which are coordinated from head office. There is comprehensive insurance covering the business throughout the term of the Agreement. Remuera Care Home does not assign any service delivery to another provider.

There is a least one registered nurse on duty or on call at all times (confirmed in discussion with the facility/village manager). Both the facility manager and the clinical manager are employed fulltime (ie, 40 hours a week). The facility/village and the clinical manager have both completed at least eight hours of professional development activities related to managing the facility. Both managers are supported by head office staff. Both managers attend annual organisational forums and regional forums six monthly.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

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

Attainment and Risk: FA

Evidence:

Remuera Care Home utilises the well-established Bupa quality and risk management system. The quality and risk management system is outlined in the quality manual which is available electronically on the intranet and in hard copy. The system is well understood and implemented by staff. The facility has a quality plan which is monitored by head office.

There are policies and procedures which are developed by head office quality and risk team to match current good practice and relevant contractual and legislative requirements. Policies are reviewed at least every five years or earlier if there is a change in process (ie, legislation or practice necessitating review). The review period is documented in the document control policy. Documents are approved, up-to-date, available to staff and managed by quality and risk at head office to preclude the use of obsolete documents. Key components of the quality and risk management system include but are not limited to resident satisfaction, adverse event reporting, health and safety, infection prevention and control, and restraint minimisation.

Quality improvement data are collected, analysed, evaluated and results are communicated to staff, and where appropriate consumers and relatives. Results are communicated to head office for review and benchmarking between Bupa sites.

The managers implement corrective action plans where opportunities for improvement are identified. Data are collected for all adverse events, hazards, infections (actual and potential), resident weights, medicine errors, wounds, the use of restraints and enablers, and resident satisfaction. Data, analysis and trends are discussed at facility meetings and trend graphs for all quality data are displayed on the staff notice board for all staff to see (sighted). Results are well documented (minutes of quality meeting held 21 August 2014 sighted). The previous audit identified that corrective actions were not being implemented and signed off when completed. This shortfall has been addressed and is an improvement from the previous audit.

The facility/village manager reports to the operations manager weekly against the facility quality plan and any adverse events or potential risks which need to be drawn to the attention of head office.

There is an annual internal audit programme in place which is overseen by head office. Internal audit results are reported to head office and results are displayed in the staff room. Opportunities for improvement are identified and corrective actions implemented if compliance is less than certain levels as specified in policy.

Actual and potential risks are identified, monitored, analysed and reviewed. There is a hazard register in place and displayed by the front entrance for visitors and contractors (sighted). 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. 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.

Resident and family satisfaction is monitored annually. Satisfaction is high. There are regular resident and family meetings held (confirmed in discussions with six of six residents and two of two relatives. Minutes are maintained (minutes sighted for August 2014, July 2014). The AGM of Corporate Trust Limited was held June 2014 for the three remaining residents that have a licence to occupy rooms within the rest home). Issues raised are documented and followed up and reported at the next meeting. Corrective action plans are implemented for areas requiring improvement.

Staff confirm that they are kept up to date with quality data, trends and any required corrective actions (confirmed in discussions with two of two caregivers, the facility/village manager and the clinical manager).

Managers are aware of the need to comply with relevant legislation and to report significant adverse events.

There is policy in place to guide staff in the event of an expected and unexpected death of a resident.

Staff are required to demonstrate competencies prior to performing tasks, procedures or treatments. The clinical nurse manager holds a competency assessment register which records all care staff competencies and the date achieved and this is displayed on an excel spreadsheet in his office- sighted). Competencies include, drug administration including controlled drug administration, first aid, nebuliser use, blood sugar level recording and Insulin administration, wound management, oxygen administration, restraint management, and moving and handling. There are policies in place to guide staff in managing clinical and non-clinical emergencies.

Fall prevention strategies are in place that include the analysis of falls, and the identification of interventions on a case by case basis to minimise future falls.

There is a comprehensive health and safety and risk management programme in place. There is a Bupa Health & Safety Plan in operation across all sites. Policies are implemented and monitored by the monthly quality meetings. Risk management, hazard control and emergency policies and procedures are in place. The organisation's benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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

Attainment and Risk: FA

Evidence:

There is a system in place to manage accidents, incidents and hazards. Staff complete an accident/incident form, which is given to the clinical manager who then actions the event as appropriate which includes contacting the resident's family if they have not yet been informed. The clinical manager will record the event electronically in a database that is managed by the Quality and Risk team at head office. The form is then forwarded to the facility/village manager. A duplicate is made of the form for quality management purposes, which is held by the clinical manager. The original document is filed and noted in the list of events in the resident's clinical record file. Any corrective actions are identified and actioned. The clinical manager and the facility/village manager report on the collective data monthly. There is a hazard register in place which is on display by the entrance to the building (sighted).

There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The key risks of theft/burglary, fire, accidents & incidents, chemical incidents and disposal of waste are noted.

Management understand their requirements in regard to essential notification reporting. The process in place is that facility/village manager will contact the operations manager or the quality and risk systems coordinator if the event is determined to be Category 1 event as defined in policy.

There is an open disclosure policy in place to guide staff. Family members' report they are informed of changes in their relatives health status (confirmed in discussions with two of two relatives. The internal audit programme includes review of open disclosure practices. The last internal audit of this practice was conducted on 10 April 2014 with full compliance to requirements.

All seven of seven accident/incident forms reviewed for August 2014 identified that family were notified when the incident occurred. Residents are orientated to the service on admission. All seven of seven accident/incident forms reviewed for August 2014 included documentation to demonstrate the event was well managed and appropriately reviewed.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

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

Attainment and Risk: FA

Evidence:

Bupa has a standardised system of human resource management in place which is implemented at Remuera Care Home. There are a range of human resource policies which are in place covering recruitment, appointment, orientation, education, performance management, and exit management. There is a process of reference checking, checking of qualifications, Police record checking, checking to ensure health practitioners maintain current practising certificates (which is monitored on an ongoing basis by the facility/village manager who holds copies of all current practising certificates) (sighted).

Five staff files were reviewed of staff who were interviewed which included the employment records of the clinical manager, two caregivers (one newly appointed and one who is medicine competent), the activities coordinator and a cook. All five of five staff files documented appropriate employment practice (eg, all five of five staff have a signed contract of employment, a job description matching their position, records of qualifications, records of orientation and records of ongoing education).

There is a documented training and education policy and procedure that describes the education programme. Mandatory training and site specific education is provided. Staff report there is training every month (confirmed in discussions with two of two caregivers and the clinical manager). Training is a component of the competency based pay scale. There is a training programme in place for the 2014 calendar year which is on display within the facility. Opportunistic education is provided by way of tool box talks. There is a registered nurse training day provided through Bupa that covers clinical aspects of care (eg, wound management and catheterisation). External education can be accessed through the DHB if required. Details of training sessions are retained and logs of training for individual staff are maintained. Attendance at training sessions is good. Registered nurse competencies are overseen by each manager. Both managers are registered nurses and as such participate in the Bupa PDRP system for recognition of professional development. All newly engaged staff receive an orientation (confirmed in review of five of five staff files and in discussions with the two newly appointed managers). Registered staff are required to demonstrate competencies in medicine management, wound management and other technical skills needed by residents. RN competencies include but are not limited to: assessment tools, blood sugar level testing and Insulin admin, medicine management including controlled drug administration, moving and handling, nebuliser management, oxygen administration, restraint management, wound management and the use of the T34 syringe driver. Both registered nurse managers have current annual practising certificates and current first aid certificates (sighted). There is an ongoing programme of staff development. Caregivers are strongly encouraged and financially incentivised to complete Careerforce Training (confirmed in discussions with two of two caregivers). 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.

The previous audit identified that competencies were not being maintained in accordance with Bupa policy. The clinical manager maintains a spreadsheet of all care staff and required competencies. The spreadsheet was up-to-date on the day of audit. This is an improvement since the previous audit.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

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

Attainment and Risk: FA

Evidence:

The service has a staffing rationale policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing ratios are monitored by head office. The facility/village manager advised that staff are very stable with a low turnover. Caregivers are managed by the clinical manager. The clinical manager and two of two caregivers reported that the levels of staff providing clinical care at any one time are appropriate. Typically there are two managers and three to four caregivers on duty on a morning shift (one caregiver finishes early at 10.30 am and then does the laundry). There are typically three caregivers on an afternoon shift (with one working 4 pm to 7 pm) and two caregivers on a night shift with on call support by one of the two managers. Currently the facility/village manager is living onsite.

Residents believe that staffing numbers and response times to requests for assistance are appropriate (confirmed in discussions with six of six residents and two of two relatives).

The service contracts with allied health professionals on an "as required" basis, which currently includes a contracted physiotherapist who attends on request. Each resident has a general practitioner who can be called upon for additional assistance if needed.

Management are aware that they need to provide sufficient staff to meet the health and personal needs of residents. The facility is well staffed as it has a large floor plate with bedrooms and lounge areas on two levels. The size of the floor plate necessitates additional staffing.

Management are aware of the need to ensure the facility has the correct management structure in place and that there is a registered nurse either on duty or on call at all times.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

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

Attainment and Risk: FA

Evidence:

Service delivery involves the resident and their family where appropriate, in the decision making process (confirmed in discussions with the clinical manager, two of two caregivers and in review of five of five residents' clinical records). Services are provided in a timely manner by staff at times that are consistent with community norms. All care is overseen by the clinical manager with oversight by the facility/village manager. There are a number of policies and associated procedures and forms in place that guide service provision (eg, admission role of caregiver policy, admission role of a registered nurse policy, admission nursing assessment policy and admission checklist.)

Assessments are completed within 24 hours of admission (confirmed in review of five of five clinical records). Long term care plans are completed within three weeks of admission. Care plans are written and reviewed by the clinical manager when the resident's current health changes. Evaluations are completed at least six monthly.

Activity assessments and the activities sections in care plans are completed by the activities coordinator. Residents and relatives are involved in care planning and in evaluating care (confirmed in discussions with six of six residents and two of two relatives). There are records of communications with family and/or family participation in decision-making related to care (confirmed in review of five of five clinical records).

There is a handover at commencement of each shift using the Bupa handover template (afternoon handover witnessed). Each caregiver receives a report on the status of the residents that they are required to care for during their shift. The report is based on the care plan and short term care plans which are available to all staff.

Five of five resident files reviewed identified that the general practitioner had seen the resident within two working days of admission. There are a large number of general practitioners who service the current rest home residents. Rest home residents typically visit their general practitioners off site as most general practitioners do not routinely provide home visits. This presents challenges to the rest home staff and therefore, where appropriate, senior caregivers will escort residents when visiting their general practitioners to ensure appropriate communication and documentation occurs. This increases the need for staffing. The rest home has just entered into a contract with a general practitioner who will provide an onsite service twice a week and onsite/on call services for 24 hours a day, seven days a week. This service is due to commence on 1 October 2014 for those residents (and family) who choose this option. Management anticipate that this system will greatly improve the overall medical service provision for residents and staff. A general practitioner was interviewed who spoke highly about the service and appreciated staff accompanying residents to the practice.

A range of assessment tools are completed using Bupa templates and the assessment booklet. Assessments are completed in on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment.

Documentation is integrated in the one clinical record and a team approach is evident.

Tracer Methodology:

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

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

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

Attainment and Risk: PA Low

Evidence:

Residents' lifestyle care plans are completed by the clinical manager. Short term care plans are implemented when necessary by the clinical manager or facility/village manager as per policy. There is a list of short term care plans maintained on the white board in the nursing station to ensure there is no breakdown in communication and to provide ease of oversight by the clinical manager. Short term care plans are linked to the resident's long term care plan and integrated when appropriate. There is a record of progress made by caregivers on each shift in the resident's clinical records (evidenced in all five of five residents' files). When a resident's condition alters, the registered nurse initiates a review and if required, a visit to the general practitioner. If needed a specialist consultation is arranged. At times a short term care plan is commenced. Staff (ie, two of two caregivers and the clinical manager), believe they have all the equipment referred to in care plans and necessary to provide care, including hoists, transfer belts, wheelchairs, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All five of five residents and two of two family members were very complimentary of the care received at the facility. Each resident has a care plan (confirmed in review of five of five residents' files). Each care plan considers the resident's needs and preferences. Each resident is examined by a general practitioner within two working days of admission unless they have been seen by their general practitioner within hours of admission or have been admitted from a hospital. A summary of their examination notes is recorded (evidenced in five of five clinical records

reviewed). Thereafter they are re-examined at least monthly unless the resident's medical condition has been assessed as stable in which case they are seen at least every three months. The clinical manager has a system for monitoring which resident is due for review.

Dressing supplies are available and a treatment room is well stocked for use. Wound assessment and wound management plans are in place for six residents who between them have a total of six wounds (which include two skin tears, two ulcers, and two surgical wounds). All wounds are being well managed. The clinical manager has access to the resident's general practitioner for advice and the wound nurses from the DHB. There is a monthly wound log maintained. Wound management in-service has been provided. Staff training on wound management last occurred 23 July 2014 (attended by six staff).

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 advice is available as needed.

The facility has a comprehensive 'in service' education programme in place. Toolbox talks on areas identified as special interest occur.

During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents and families were able to confirm this observation.

A review of the events that occurred when a resident had an accident on the first day of the audit showed that documentation did not occur in a timely manner consistent with current accepted good practice and Bupa policies.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

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

Attainment and Risk: PA Low

Evidence:

The clinical care provided to the resident who fell on the day of audit occurred in a timely manner. Staff on duty ensured the resident was appropriately cared for and in the absence of the resident's family, ensured the resident was seen and reviewed by her general practitioner within the first hour following the event. Services were provided that met the resident's assessed needs and both the resident and her daughter were grateful. Documentation of the event was not consistent with current accepted good practice although staff had received refresher training on accident/incident reporting and open disclosure on 2 April 2014 (when six staff attended) and refresher training on observations and reporting changes on 21 May 2014 (when seven staff attended). Baseline neurological observations were not recorded on the neurological observation sheet and it is unclear whether neuro observations were taken between 8 pm and 2 am when the instruction was to take these recordings four hourly. The call to family was not recorded in the resident's records on the day of the incident or the accident/incident form. No written instructions were documented by the general practitioner on the day of the accident and brought back to guide staff overnight. The writing of clinical instructions for residents in the care manager's report and not in progress notes is not accepted practice. Failure to record property damage to eyeglasses is not consistent with policy.

Finding:

Documentation of the accident that occurred on the first day of audit was not consistent with current accepted good practice or Bupa policies.

Corrective Action:

Ensure documentation occurs in a timely manner consistent with accepted good practice and policies.

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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

Attainment and Risk: FA

Evidence:

Each resident has a written and implemented activities programme, which is developed within the initial weeks of admission following an assessment which includes obtaining a complete history of the resident's past and present interests and life events. Their participation in the activities programme is reviewed six monthly as part of the resident's multidisciplinary review (confirmed in review of five of five residents records). The activities programme includes group and individual activities and involvement with the wider community. A record of each resident's participation in the activities programme is maintained by the activities coordinator and a record is maintained in their clinical record.

There is one activities co-ordinator who is employed full-time five days a week (interviewed). The activities coordinator provides a group programme for any resident who wishes to participate. The group programme is provided in differing areas throughout the facility to increase stimulation. On the days of audit residents were observed being actively involved with a variety of activities in various areas. The group programme is developed monthly and weekly programmes are displayed in large print throughout the facility. The programme includes networking within the community with social clubs, churches and schools. The programme includes cognitive stimulation activities (eg, newspaper readings, puzzles, crosswords, and quizzes), physical stimulation (eg, exercises, floor bowls, garden walks, van rides to the community) and socialisation events (eg, happy hours, singing, birthday celebrations, and themed dinners) and church services are held onsite. Participation in all activities is voluntary.

Residents and family members stated they were happy with the activities programme and that residents were given choices regarding participation (confirmed in discussion with six of six residents and two of two families). Resident satisfaction in the 2013 Satisfaction Survey showed that 90 percent of respondents believed the activities programme was meaningful. No one was dissatisfied with the programme. The remaining 10 percent of respondents ranked the programme with a neutral ranking.

Residents meetings occur monthly (minutes sighted). Most residents are cognitively able to make their needs known and many are very active physically.

The facility has its own van with wheelchair access (which is a 12 seat van and hoist capable). Van outings occur at least three times a week usually. A van driver is contracted to drive the van, as it requires the driver to have a heavy duty licence (which no staff have). The van driver is always accompanied by staff, which is usually the activities co-ordinator who has a current first aid certificate (sighted) and a learner's driving licence (sighted).

The activities programme is included in the internal audit programme. The latest internal audit of the programme was conducted 17 July 2014 which showed compliance and did not identify any corrective actions.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

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

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

Attainment and Risk: FA

Evidence:

All initial care plans are evaluated by the clinical manager within three weeks of admission. All care plans are reviewed by the clinical manager and amended where necessary to address current needs. Care plans are evaluated six monthly or more frequently as clinically indicated. Resident centred care plan evaluations are up to date (confirmed in review of five of five residents' records). Six monthly evaluations or earlier occur if a resident's health changes (confirmed in discussions with the clinical manager, six of six residents and two of two family members). Evaluations are completed by the clinical manager with input from the general practitioner, caregivers, the activities coordinator, the resident and family if available, and any other relevant person involved in the care of the resident (confirmed in discussions with the clinical nurse manager and the activities coordinator). The activities plan is reviewed at the same time. A written multidisciplinary review (evaluation) is completed against the long term care plan's desired goals and progress/achievement towards the goals are recorded. Short term care plans are used and evaluated, resolved or added to the long term lifestyle care plan if the problem is on-going. Short term care plans are used for acute problems (eg, infections, wounds, skin conditions, and the onset of frequent falling). Short term care plans are documented in a plan which is then linked to the care plan. The internal audit programme includes review of care planning evaluation practices. The last internal audit for evaluations was conducted on 14 August 2014 with full compliance to requirements.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

Attainment and Risk: PA Low

Evidence:

There are policies and procedures in place to guide staff on medicines management. All medicines are charted by the residents' GP (confirmed in review of ten of ten medicine charts). The facility has a contract in place for medicine supply with a local pharmacy. Tablets are packaged using the robotics system. Non-tablet medicines are supplied in pharmacy labelled containers. Staff have access to online medicines information from the pharmacy, the GP and MedSafe.

Medicines are administered by a mix of care staff including caregivers, the clinical manager or facility/village manager. The caregivers have been assessed as competent by the registered nurses who have been assessed as competent (confirmed in discussion with the facility/village manager, the clinical manager, and two of two caregivers; and in review of employment records of the clinical manager and two of two caregivers). A medicine round was observed and was conducted by a caregiver according to accepted practice. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medication management training was held in 9 April 2014 (when six staff attended).

Warfarin administration occurs and is being well managed according to Bupa policy which was developed in consultation with a DHB.

There are no residents self-administering medicines. The facility does not use standing orders.

GPs conduct reviews of residents three monthly to ensure medicine supply and this date is recorded in the medicine record. The clinical manager use a diary system to ensure compliance is maintained. Staff will often accompany residents to their reviews to ensure documentation occurs. There is one treatment room on the ground floor which service both levels.

There is one custom built medicine trolley in use which is able to be locked. Medicines not requiring refrigeration are stored in a locked cupboard in the nurses' station. Medicines requiring refrigeration are stored in an unlocked refrigerator in the nurses' station, which is also not able to be locked (refer finding 1.4.2 below). Controlled drugs are individually prescribed and packaged and stored in the nurses' station in a locked cabinet that complies with the regulations for controlled drug storage. Two competent staff members check out controlled drugs prior to administration. A six monthly pharmacy audit is completed. Medicines no longer required are quarantined and returned to the pharmacist. Medicine reconciliation occurs when patients are admitted with medicines. All medicines received in the facility are checked on arrival. The pharmacy can

deliver every day if needed. Any discrepancies would typically be documented and the error fed back to the pharmacy (There have been no discrepancies noted since the previous audit). Staff sign Douglas Pharmaceuticals designed medicine administration charts which are produced by the pharmacy. Staff then initial once they have administered a medicine to a resident.

The internal audit programme includes a review of the medicines management system. The last internal audit was conducted on 12 February 2014 which resulted in 57 percent compliance. A number of corrective actions were identified and corrected.

Ten of ten medicine charts were sampled for review. All ten of ten charts included recent photo identification, indications of allergies/adverse reactions, and any special instructions for administration on the medicines chart. The prescribing met legislative requirements except for the prescribing of PRN medicines for two of the ten resident files reviewed. The signing sheets were correctly signed.

The findings from the previous audit identified that medicine charts were not reviewed by a general practitioner every three months; that the general practitioners were not updating medicine charts when medicines were changed; that medicine administration records were not clear as to what medicines had been administered; and that medicines were not being administered as prescribed. A review of ten of ten medicine charts showed that these shortfalls had been addressed. This is an improvement from the previous audit.

This audit identified an improvement required around the charting of PRN medicines in two of the ten medicine records reviewed (refer 1.3.12.1 below) and it identified the need to lock the nurses station when not attended (refer 1.4.2 below).

D16.5: All 10 of 10 medicine charts sampled identified that the GP had seen and reviewed the resident at least three monthly and the resident's medicine chart was signed accordingly.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

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.

Attainment and Risk: PA Low

Evidence:

Eight of ten medicine charts reviewed showed that PRN (as needed) medicines are charted correctly. The sample was extended but no further evidence of non-compliance was found. The clinical manager reported that there has been considerable improvement made to charting since the previous audit. Ensuring charts are correct has been complicated by the high number of general practitioners servicing residents and their practice of seeing residents in their rooms off site. Staff now accompany residents to ensure documentation is completed correctly and a new onsite general practitioner system is being implemented on 1 October 2014.

Finding:

Two of ten medicines charts reviewed showed that the prescriber had not recorded specific target symptoms for the administration of PRN (ie, as needed) medicines.

Corrective Action:

Ensure prescriber orders for all PRN medicines include target symptoms.

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)***Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)**

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

Attainment and Risk: FA**Evidence:**

The facility employs two cooks and three kitchen hands. The head cook (interviewed) works fulltime and she alternates shifts with another second cook. They prepare all three main meals and snacks according to the Bupa national menu. Summer and winter menus are organised on a six weekly cycle and are used on a weekly rotational basis and the menus are available on the intranet. The national menus have been audited and approved by an external dietitian. The menus were last reviewed in March 2013.

Food is procured from commercial suppliers. The kitchen supplies all meals and most food served is cooked onsite. Meals for residents wishing to eat in their rooms are plated up by kitchen staff and staff then pick up the food and deliver at the same time to ensure the food remains hot (sighted).

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. The kitchen is included in the internal audit programme (last audit conducted 11 August 2014 which showed 94 percent compliance (some canned food was not dated and this has been corrected (sighted)).

Each resident has a nutritional profile developed on admission which identifies their dietary requirements and their likes and dislikes. This information is provided to the kitchen staff and reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen (confirmed in interview with the cook). Special diets can be catered for as needed (eg, vegetarian and soft/pureed diets).

Residents participate the annual satisfaction survey which includes reference to the food service. The food service is discussed at resident meetings and comments from these meetings and individual resident feedback are discussed at staff meetings. Residents and family report satisfaction with food choices and the food service (confirmed in discussions with six of six residents and two of two relatives). Meals are well presented (observed) and alternative meals are offered as required. Residents advise the cook on the day if they want an alternative choice of food and this is catered for and provided at the time. There is a cook on duty from 10 am to 6.30 pm each day and a kitchen hand starts earlier and finishes later than the cook. A continental breakfast is served which includes porridge which is cooked by slow cooker overnight (and set up by the cook before they end their shift). The cooks have been trained in safe food handling.

Residents are provided with adequate and nutritious meals, refreshments and snacks at times that reflect community norms, take account of likes and dislikes, and meets the nutritional requirements of older persons. The kitchen stocks at least three days' supply of food to assist in emergency management should food supply be disrupted.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

Attainment and Risk: PA Low

Evidence:

There is a current building warrant of fitness which expires 25 June 2015.

The previous audit identified that hot water temperatures accessible by residents were not being maintained at a safe temperature and there was no evidence of corrective actions being taken. There is evidence of corrective actions being taken when temperatures greatly exceed 45 degrees Celsius however further improvements need to occur to address this matter (refer 1.4.2.1).

Although hot water temperatures are being actively managed in residents' rooms, there is a large zip hot water cylinder located upstairs in the common area kitchenette which is able to be used freely by residents, relatives and is used daily by staff. The zip cylinder has a tap that represents a potential burn hazard (refer 1.4.2.1). The burn hazard is not itemised on the site hazard register. There are residents in the facility who have a degree of cognitive impairment for whom the zip represents a risk. There are occasions when staff are not in attendance in the common area on this floor.

The nurses' station on the ground floor is not able to be locked when not in use. It contains clinical information and refrigerated medicines that are not able to be stored securely (refer 1.4.2.1).

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The previous audit identified that hot water temperatures accessible by residents were not being maintained at a safe temperature and there was no evidence of corrective actions being taken. The hot water temperatures of taps accessible by residents rooms remains a source of concern although the risk is considered low and there is no evidence of a resident being harmed. The facility plumbing has been designed in such a way that each bedroom has its own hot water cylinder that feeds the kitchenette, then the shower then the hand basin in the ensuite. The maintenance man is aware of the need to maintain hot water temperatures at the taps at 45 degrees Celsius but is not able to achieve this compliance on all taps due to the current plumbing design. All taps in the bedrooms have mixers so none are able to dispense hot water only. Each cylinder has a temper valve installed. The maintenance man monitors the temperatures of all taps every month. The problem is that if he keeps the kitchen tap temperature at 45 degrees then the shower temperature will be colder than 45 degrees and the temperature of the water in the hand basin will be even colder. Residents complain if they

have cold showers. He has therefore chosen to maintain the temperatures of their showers at 45 degrees to (a) ensure that the area of greatest risk is managed effectively, and (b) to ensure that residents do not find the shower is too cold if they are showering for any length of time (which happens). The net result is that some temperatures in the kitchen area are recorded at 46 degrees. There is plenty of evidence to show that correct actions are taken if significantly higher temperatures are detected. Further improvements or discussions need to occur to address this matter.

There is a large zip hot water cylinder located upstairs in the common area kitchenette which is able to be used freely by residents, relatives and is used daily by staff. The zip cylinder has a tap that represents a potential burn hazard. This hazard is not noted on the facility hazard register. No residents have been harmed by this hazard to date.

The nurses' station on the ground floor is not able to be locked currently. It is used to store a range of clinical information and there is information on white boards that needs to be maintained securely to assure resident privacy. In addition the room is used to store the medicines trolley and the medicines refrigerator.

Finding:

The hot water temperatures at the taps in residents' rooms continue to be above 45 degrees Celsius and the hot water cylinder in the upstairs kitchenette is a burn hazard. The nurses' station located on ground floor needs to be able to be locked when not in use to ensure clinical information and refrigerated medicines are stored safely.

Corrective Action:

Ensure the hot water temperatures at the taps in residents rooms are maintained at 45 degrees Celsius or below and ensure that the hot water cylinder in the upstairs kitchenette does not present a burn hazard. Ensure the nurses' station located on ground floor is able to be locked when not in use.

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint practices are overseen by the restraint coordinator who is the clinical manager. The facility is restraint free. Policies and procedures are comprehensive; include definitions, processes and the use of enablers. Staff are trained in challenging behaviour management and policy (last education provided 16 July 2014 attended by eight staff).

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

Bupa's infection prevention and control committee determines the type of surveillance required and the frequency with which it is undertaken at the facility. This is outlined in the surveillance policy, which describes and outlines the purpose and methodology for the surveillance of infections. The infection prevention and control coordinator at the facility is the clinical manager who is experienced in infection prevention and control having worked in the role for three years within Bupa. The infection prevention and 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 information is kept as part of each resident's file. Infections are included on a monthly register and a monthly report is completed by the infection prevention and control co-ordinator and forwarded to head office. Definitions of infections are in place appropriate to the complexity of service provided. Infection prevention and control data are collated monthly and reported at the quality, and infection prevention and control meetings. The infection control programme is linked with the quality management programme. The results are subsequently included in the report on quality indicators returned to the facility by head office. Education on infection prevention and control occurs (last session November 2013 attended by seven staff). Internal infection control audits also assist the service in evaluating infection control needs (last internal audit was conducted 7 August 2014 with 96.2 % compliance and corrective actions related to hand washing were identified and corrected at the time of audit by individual teaching). There is close liaison with the visiting general practitioners who will advise and provide feedback /information to the service as needed. Systems in place are appropriate to the size and complexity of the facility. The facility has not had an outbreak in the period between audits.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*