

Bupa Care Services NZ Limited - Glenburn Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Glenburn Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 October 2014 End date: 21 October 2014
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	101

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bupa Glenburn provides rest home, hospital, dementia and psychogeriatric levels of care for up to 103 residents. On the day of audit there were 101 residents (51 of 52 hospital level residents, 25 of 26 rest home residents, 13 of 13 residents in the dementia unit and 12 of 12 psychogeriatric residents (includes one respite). The service is managed by an experienced social worker who has been the facility manager at Glenburn for seven years. She is supported by a clinical manager (registered nurse) who has been in this position for four years. Support is also provided by the operations manager.

All of the seven shortfalls identified in the previous audit have been addressed. These were around corrective action plans, restraint, accident/incident interventions, short term care plans, aspects of medication administration, nutritional records and serving temperatures have all been addressed. This audit identified improvements required around meeting minutes and documentation of clinical interventions (including restraint risks) in the care plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Relatives interviewed confirm they are well informed of incidents/accidents and changes of health status. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Glenburn is implementing the organisational quality and risk management system that supports the provision of clinical care and support. Quality and risk performance is reported to the organisation's management team. Benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Glenburn is benchmarked in four of these (hospital, rest home, dementia and psychogeriatric). There is one improvement required around meeting minutes consistently recording discussion of key components of the quality system. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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A registered nurse completes assessments, care plans and evaluations within the required timeframes. There is documented evidence of resident and/or family/whanau input into the care planning and review process. Care plans are reviewed at least six monthly. This audit identifies an improvement required around documentation of interventions to reflect the residents' current health status. Resident files include notes by the GP, mental health services, consultant psychiatrist, dietitian, physiotherapist and other allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed monthly by the general practitioner. The previous findings around aspects of medication administration, reconciliation and transcribing have been addressed. There no findings identified in this audit.

A seven day week activities programme is implemented separately for the rest home/hospital area and for the dementia and psychogeriatric care units. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the consumers groups.

All food and baking is done on site. Bupa menu plans are reviewed by a dietitian. All residents' nutritional needs are identified and documented. Choices are available and are provided. Nutritious snacks are available in the dementia and psychogeriatric unit at all times. Previous shortfalls around serving temperatures and nutritional records have been addressed.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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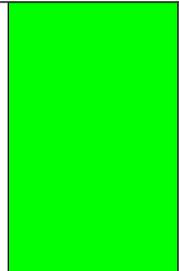
The building holds a current warrant of fitness. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are easily accessed, safe and well maintained. There is a separate safe external walking path and gardens for the dementia care and psychogeriatric residents that are freely accessible. Electrical equipment is checked annually. All medical equipment and all hoists are serviced and calibrated annually. Hot water temperatures are monitored.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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 process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service currently has ten residents assessed as using a restraint and two enablers in use. A register for each restraint is completed. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and challenging behaviour. Restraint competencies are completed regularly.

Infection prevention and control

<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>
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The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections, which have been completed as per internal audit schedule.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	2	0	0	0
Criteria	0	42	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure (065) states 'The care home 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 spread sheet'.</p> <p>There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards.</p> <p>There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with seven residents and three relatives confirm they were provided with information on. Complaint forms are visible for residents/relatives in various places around the facility.</p> <p>There are two recorded complaints for the 2014 year (one verbal, one written). Both are well documented including investigation, follow up and resolution.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at</p>

		entry
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incident, category ones (i.e., major resident incidents), complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is a policy to guide staff on full and frank open disclosure practices. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. 16 incident forms reviewed from between August and October 2014 (all service types) identified family were notified following a resident incident. Incident/accident forms are audited as part of the internal auditing system and a criterion is identified around "incident forms" informing family. The audit was completed in April (2014) confirmed family notification.</p> <p>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.</p> <p>At an organisational level, a residents/relatives association provides 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.</p> <p>Interpreter policy and contact details of interpreters. A list of Language Lines and Government agencies is available.</p> <p>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</p> <p>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.</p> <p>D16.4b Three relatives (one hospital, one dementia, one psychogeriatric) state they are informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and this can be read to residents.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>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. Glenburn 2014 quality goals include reduction in skin tears and falls by 10% and reduction of pressure areas by 20%. Interview with the facility manager informs progress is being made. Progress towards the goals is also reported through the quality meeting minutes.</p> <p>Bupa Glenburn provides care for up to 101 residents across four service levels (hospital, rest home, dementia and psychogeriatric care). On the day of audit there were: 51 of 52 hospital level residents, 25 of 26 rest home residents, 13 of 13 residents in the dementia unit and 12 of 12 psychogeriatric residents. Included in this total is one respite resident in the psychogeriatric unit. There are no residents under the medical component at the time of audit.</p> <p>In 2009, Bupa introduced a person centred care focus which includes six pillars. This has been embedded in service delivery at Glenburn. 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) will also be tabled at this forum.</p> <p>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 has commenced.</p> <p>The managers in the region teleconference monthly and meet six monthly. A forum is held every six months (with national conference) including all the Bupa managers. Glenburn's annual goals link to the organisations goals and this is reviewed in quality meetings and followed through in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Glenburn is implementing the "personal best" initiative whereby staff are 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 including - knowledgeable staff / meaningful activities / comfortable environment. 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</p>

		<p>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 have been implemented. 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.</p> <p>The Bupa CNS 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. 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.</p> <p>The service is managed by an experienced manager (social worker) who has been the facility manager at Glenburn for seven years and previously managed another aged residential service in the region. She is supported by a clinical manager (registered nurse) who has been in this position for approximately four years. Support is also provided by the operations manager.</p> <p>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), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Glenburn is implementing the Bupa quality and risk management system. The service has policies and procedures that are being implemented 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 associated clinical forms. 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</p>

	<p>policies. A policy and procedure review committee 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.</p> <p>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. The release is notified by email to all clinical/Care Home 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.</p> <p>Key components of the quality management system link to the bimonthly quality meeting at Glenburn. Reporting by the facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the clinical manager that break down the data collected across the hospital, rest home, dementia unit and psychogeriatric services, and staff incidents/accidents. While all aspects of the quality system are discussed at the quality meeting, this is not consistently recorded in staff meeting minutes and is an area for improvement.</p> <p>Weekly and monthly manager reports include complaints. The Glenburn infection control committee meet bimonthly and the weekly reports from the facility manager cover infection control. Infection control is also included as part of benchmarking across the organisation. There is an organisational regional IC committee. The health and safety committee meets monthly and is also an agenda item at the quality committee.</p> <p>Glenburn is implementing the Bupa quality and risk management process. 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 Glenburn graphs and benchmarking reports (sighted). Corrective actions</p>
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		<p>identified as part of the internal audit activity are closed out on the corrective action plan; this is an improvement from the certification audit.</p> <p>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 and the like throughout the year.</p> <p>Benchmarking of 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 key indicators with another NZ provider has commenced. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action forms are being adopted at Glenburn and document actions that have improved outcomes or efficiencies in the facility.</p> <p>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 an H&S coordinator whom monitors staff accidents and incidents. There is a Bupa Health & Safety Plan for with two objectives that include the Bfit programme (for staff) and a reduction by 10% in staff injury. On-going review of objectives for Glenburn is seen in H&S meeting minutes.</p> <p>D19.2g: Falls prevention strategies are in place that includes 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 limb protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>D19.3c: The service collects incident and accident data. Category one incidents policy (044) includes responsibilities for reporting Cat one incidents. The completed form is forwarded to the quality and risk team as soon as possible (definitely within 24 hours of the event), even if an investigation is on-going.</p> <p>Sixteen incident forms were reviewed in detail (four from each service area) during September and October. All forms reviewed were completed appropriately and signed off by the facility manager. There is evidence of the use of a physical assessment tool following falls, neuro observations for unwitnessed falls and/or falls when a knock to the</p>

		<p>head was reported, pain assessments and use of short term care plans (STCP's) for skin tears/wounds. Follow up was seen to have been reported in progress notes of the eight files reviewed.</p> <p>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.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Register of registered nurse (RN) and enrolled nurse (EN) practising certificates is maintained, both at facility level and 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 including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (clinical manager/infection control officer, unit coordinator/restraint officer, one registered nurse, three caregivers, chef, activities coordinator and van driver) and all had personal file checklists. Performance appraisals are current and there is a schedule in place to track progress.</p> <p>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. Staff interviewed (seven caregivers, two registered nurses, one enrolled nurses) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>Interview with the clinical manager confirmed 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 three unit standards. These align with Bupa policy and procedures. There is an annual education schedule that is being implemented. There is an RN/EN training day provided through Bupa that covers clinical aspects of care - eg. wound management. External education is available via the DHB. There is evidence on RN staff files of</p>

		<p>attendance at the RN training day/s and external training.</p> <p>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 on 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 are aware of the requirement to complete competency training.</p> <p>Bupa is the first aged care provider to have a nursing 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.</p> <p>There is a staff member with a current first aid certificate on every shift, and the refresher was provided in July (2014) where 11 staff attended.</p> <p>E4.5f: 1Fourteen of the 15 staff working in the dementia and psychogeriatric wings hold qualifications or are completing the dementia qualifications through career force. The remaining staff member is in the process of completing the modules.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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.</p> <p>There is at least one RN and a first aid trained member of staff on every shift. Interviews with seven caregivers inform the RN's are supportive and approachable. There are a variety of shift hours through the morning and afternoon and on night duty there are 3x RN's and 4x caregivers across the facility.</p> <p>Interview with staff, seven residents and three relatives inform there are sufficient staff on each shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely</p>	<p>FA</p>	<p>Medications are managed appropriately in line with accepted guidelines. . Registered nurses, enrolled nurses and senior caregivers have completed medication</p>

<p>manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>competencies to administer oral medications, insulin and controlled drugs. RNs complete syringe driver medications. All medication competent staff have completed annual medication competencies for oral administrations, controlled drugs and insulin competencies. RNs complete additional competencies for syringe driver. Medication education is delivered annually. The service uses robotic roll system for regular medications and prns are dispensed in bottle. All medications are checked on delivery against the medication chart and signed off on the medication delivery sheet. Any discrepancies are fed back to the supplying pharmacy. Inventory, pharmacy stock and prn medications are checked weekly.</p> <p>There is a supply of hospital stock held in the locked drug cabinet in the hospital wing. The pharmacy conduct a six monthly audit. The standing orders are current and meet the requirements for standing orders. All eye drops currently in use in the medication trolleys are dated on opening. The medication fridge temperatures (hospital and dementia units) are checked at daily and temperatures are within acceptable ranges. Oxygen and suction is available and checked weekly (checklist sighted).</p> <p>There are currently two rest home residents who self-administer their medications when on day outings with family. There are self-medication competencies in place that have been reviewed three monthly.</p> <p>Sixteen (four rest home, four hospital, four dementia care and four psychogeriatric) resident medication signing sheets are sampled. Signing sheets correspond to instructions on the medication chart. Two medication competent staff the signing sheet for controlled drugs.</p> <p>PRN medications are signed, dated and timed on administration. There are no signing gaps. There is no transcribing. The previous shortfalls regarding transcribing, signing gaps, controlled drug administration and reconciliation for short term residents have been addressed. The medication folder contains information on crushable medications and management of hypoglycaemia and hyperglycaemia. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies e) short course medications f) warfarin. Iowa and modified abbey pain assessments and blood sugar level recordings are kept with the resident medication chart. Antipsychotic medication management plans are in place for residents on these medications.</p> <p>Sixteen medication profiles sampled are pharmacy generated, up to date and reviewed at least three monthly by the G.P. There are photos and allergy status documented on all 16 medication charts sampled.</p> <p>16.5.e.i.2: Sixteen medication charts sampled identified that the GP had seen the</p>
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		reviewed the resident at least three monthly and the medication chart is signed.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'. There is a monthly on-line forum for all Bupa facilities cooks. The chef (interviewed) on duty from 9am-5.30pm and is supported by a cook and kitchen assistant daily. There is an evening kitchen hand to assist with the evening meal and dishes</p> <p>The national menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in bain Maries to the rest home and hospital dining rooms. Meals are plated and delivered in scan boxes to the dementia and psychogeriatric unit. This is an improvement since the previous audit. Special diets (includes vegetarian, diabetic desserts and pureed meals) and alternative choices for dislikes are accommodated. Indian dishes and curries are prepared and frozen to meet the cultural food preferences of the Indian residents. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. There is evidence of nutritional records being maintained for residents who are being monitored for weight loss. The nutritional record also records if a resident has declined foods. This is an improvement since the previous audit. The records are maintained in the clinical areas. There are daily menus in each area for each day. There are three choices for the evening meal. Daily hot food, end cooked and serving temperatures are taken and recorded. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. The kitchen is well equipped to cater for the number of meals produced. Chemicals are stored safely. Cleaning schedules are maintained. Staff are observed to be wearing personal protective clothing. 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.</p> <p>Residents provide verbal feedback on the meals and through the resident meetings and surveys.</p> <p>E3.3f; ARHSS D15.2f; There is evidence of additional nutritious snacks available over 24 hours available in the dementia and psychogeriatric unit kitchenette and fridge which includes bread, biscuits, yoghurts, mousses and fruit. The kitchen is accessible to staff after hours.</p>

		D19.2; Food services staff have completed food safety and hygiene course and chemical safety.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>The registered nurses complete residents' care plans. A care summary is readily available for caregivers. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP, or nurse specialist consultation. There is documented evidence written on the family/whanau contact record of family notification when a resident health status changes including infections, incidents/accidents, GP visits, medication changes, care plan reviews, challenging behaviours, appointments and transfers. Three relatives (one dementia care, one psychogeriatric care and one hospital) interviewed confirm they are notified with any RN resident concerns and any significant events. They state the staff are very approachable if they wish to discuss their relative's health at any time and they are invited to the multidisciplinary (MDR) reviews. The previous finding around documentation of corrective actions from accidents/incidents into the care plans has been addressed. This audit identifies there is an improvement required around documentation of interventions to reflect the residents current health status.</p> <p>D18.3 and 4 Dressing supplies are available and sighted in all treatment rooms. Dressing trolleys are well stocked. Staff report that there are always adequate continence supplies and dressing supplies. 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. The hospital unit co-ordinator (interviewed) states the nursing specialists for wound and continence management through the district health board are supportive and readily available for advice and education. The rest home has one minor wound and one skin tear. The dementia unit has one resident with an infected large toe and another with two skin tears. There are no wounds in the psychogeriatric unit. In the hospital there is one resident with a chronic leg ulcer, another with chronic skin breaks/ulcers and there are seven skin tears. There is a resident with a chronic sacral pressure area since July 2013 which developed a cavity. There has been wound nurse specialist input and surgical review. Photos are in place. The dietitian has been involved and the resident is on cubitan drinks. Another hospital resident has a grade 1 heel pressure area and a grade 2 leg pressure area. All wounds have an initial wound assessment completed, a wound care chart and evaluations completed as per the documented frequency. Pressure area interventions and a pressure area plan is included in the long term care</p>

		<p>plan and include the use of a pressure area mattress and pressure relief cushion.</p> <p>The dietitian and speech language therapist are available by referral with a telephone response time of two to three days.</p> <p>Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning chart, lowa pain monitoring tool and neurological observations. Residents diagnosed with dementia and/or challenging behaviours have a dementia specific needs care plan that includes the types of behaviour, triggers and alternative strategies and distractions (including activities) to manage behaviours. A behaviour analysis tool is used to identify behaviours and management strategies. Behaviour monitoring charts are commenced for any new or escalating behaviours (sighted).</p> <p>ARHSS D16.4; There is good specialist input into residents care in the psychogeriatric (PG) a unit. The GP is notified to assess a resident with escalating/new behaviours to exclude medical cause prior to referral to the mental health older person's service or consultant psychiatrist. The service responds promptly to referrals. The service can readily access the crisis team for more urgent situations. Strategies for the provisions of a low stimulus environment could be described by staff working within the unit and observed during the audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities co-ordinator has been in the role 12 years and has attained the career force core competencies. There are two long serving activities assistants who have completed the dementia course. There is a company occupational therapist that oversees the overall programme and meets with the team twice yearly and is available by phone if required. The activity team attend the Bupa training days and external workshops on challenging behaviour and on-site in service as required. All staff have current first aid certificates. The programme for the rest home and hospital and a separate programme for the dementia and psychogeriatric unit is planned a month in advance and covers seven days a week. On some days there are three activities persons on duty allowing dedicated time in the three areas with a variety of choice of activities for residents to attend. Volunteers are involved in the activities programme.</p> <p>The rest home/hospital programme includes activities that meet the needs and preferences of the consumer groups. Bupa has set activities on the programme that is delivered with the flexibility to add site specific activities, entertainers and outings. The rest home/hospital programme includes one on one time for residents who are unable or choose not to participate in the programme. The integrated rest home/hospital</p>

	<p>activity programme includes (but not limited to); news reading, quizzes, Sit and be fit exercise programme and walks, crafts, board games, theme days, shopping, singing, movies, reminiscing, and monthly happy hour. Programmes are displayed. Variations to the programme are made known to the residents.</p> <p>There is a separate programme for the residents in the Koru wing (dementia and psychogeriatric care) that is flexible and accommodates group and individual activities focused around cognitive, sensory and physical activities such as music, art, crafts, reminiscing, hand/foot spas/massage, household chores, gardening, walking and dance. Caregivers working in the dementia and psychogeriatric unit include activities with residents as part of their day. Resources are readily available.</p> <p>There are regular twice weekly outings for residents in the rest/home/hospital unit and twice weekly van drives for residents in the dementia unit. The service has a wheelchair hoist van and there is a designated van driver and caregiver that accompany residents on outings. Weekly entertainers are scheduled and rotate between the three areas. Dementia and psychogeriatric residents attend entertainment in other areas under supervision. Special occasions, birthdays and multi-cultural days are celebrated. There are twice monthly church services and Holy Communion weekly in all areas.</p> <p>Community links are maintained with (but not limited to); visiting pre-school and school groups visiting, SPCA pet therapy and farm animals, mobile library service, community speakers such as the police, optometrist and dentist.</p> <p>The family/resident completes a Map of Life on admission which includes previous hobbies, community links, family, and interests. The individual activity plan in all resident files sampled identify activities and community links that reflect the resident's normal patterns of life. The activity plan (incorporated into the My Day, my way long term care plan) is reviewed at the same time as the care plan six monthly at the multidisciplinary team review. Individual activities participation records are maintained. Residents have the opportunity to provide feedback on the activity programme through two monthly resident meetings and resident satisfaction surveys.</p> <p>ARHSS 16.5g.iii: A comprehensive social history is completed on or soon after admission and information gathered is included in the support plan. The activity plan is developed with the relative (and resident as able) and this is reviewed at least six monthly</p> <p>ARHSS 16.5g.iv: Caregivers are observed at various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans are reviewed and evaluated by the registered nurse at least six monthly in seven of seven permanent resident files sampled. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident such as the physiotherapist. Family members are invited to attend the MDR review. The MDR checklist identifies the family member who has attended the review.</p> <p>There is at least a one- three monthly review by the medical practitioner.</p> <p>There are short-term care plans available to focus on acute and short-term issues. These are evaluated at regular evaluations. This is an improvement since the previous audit.</p> <p>ARC D16.4a, ARHSS D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated.</p> <p>ARC D16.3c: ARHSS D16.3c; All initial care plans were evaluated by the RN within three weeks of admission</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires on 23 September 2015. Reactive and preventative maintenance occurs. There is a full-time maintenance person on staff. A 52 week planned maintenance programme is maintained. Medical equipment including hoists (checked September 2014) and wheel-on scales (calibrated April 2014) have been serviced. The hot water temperatures are monitored. There are contractors for essential service available 25/7. Electrical testing and tagging was last completed October 2013 and scheduled again for this month.</p> <p>ARHSS D15.3e ; ARC D15.3. The seven caregivers interviewed (four hospital, one rest home and two dementia/psychogeriatric care) stated that they have all the equipment referred to in care plans necessary to provide care, including electric beds, ultra-low beds, sensor mats, shower trolleys, sling and standing hoists, chair scales, wheelchairs, lazy boy chairs on wheels, mobility aids, continence supplies, dressing and medical supplies.</p> <p>E3.4d, There is a large open plan lounge area designed so that space and seating arrangements provide for individual and group activities.</p>

		<p>E3.3e; There are quiet, low stimulus areas and seating alcoves that provide privacy when required.</p> <p>E3.4.c; There is a safe and secure outside walking area and gardens with seating and shade that is easy to access for dementia residents.</p> <p>ARHSS D15.3d There is an open plan lounge and dining area with seating desinged to allow for individual and group activities.</p> <p>ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required. Residents have the freedom to move between the communal areas, bedrooms and external area. All bedrooms are single.</p> <p>ARHSS D15.3b There is a safe and secure outside area that is easy to access.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The 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 organisational level</p>

		<p>that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.</p> <p>The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has two residents on the register with an enabler in the form of bedrails and a seat belt. The service currently has ten residents assessed as requiring restraint with nine in the hospital unit and one in the psychogeriatric unit. A register for restraint used is documented and includes a monthly evaluation.</p> <p>Staff are able to differentiate the differences between an enabler and a restraint (confirmed in interviews with seven caregivers and two registered nurses).</p> <p>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.</p> <p>ARHSS D16.6: There is a managing disturbed behaviour policy.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is the hospital unit coordinator (registered nurse) and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed at least three-monthly within the facility restraint meeting. Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. Advised by the restraint coordinator that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of three hospital residents with restraint identified observations and monitoring, the risk of the restraint is not always recorded (link 1.3.6). Restraint use is reviewed through the three-monthly assessment evaluation, three-monthly restraint meetings and six monthly multi-disciplinary meetings, which includes</p>

		<p>family/whanau input. A restraint register is in place.</p> <p>The previous shortfall relating to seatbelt has been addressed – there is only one resident using a seatbelt in a wheelchair and this is an enabler. Restraints in use are bed rails and lap belts.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Glenburn has a meeting schedule in place that is being implemented including bimonthly quality meetings, qualified staff and staff meetings in each clinical area. There are also two monthly infection control meetings and health and safety meetings. All meetings are minuted.</p>	<p>Meeting minutes do not consistently record inclusion of incidents and/or internal audit. Examples include:</p> <p>a) Qualified staff meetings: In minutes sighted for 18 September 2014, 15 May 2014 and 1 January 2014 there are no recorded discussion of incidents, and the 15 May 2014 and 1 January 2014 minutes have no discussion of internal audits.</p> <p>b) Ward meetings in the four units – Manuka, Koru, Kowhai and Rata do not record incidents in the June/July meeting minutes.</p>	<p>Ensure meeting minutes include discussion about internal audit and resident incidents including trending and preventative actions.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services</p>	PA Low	<p>When a resident's condition alters, the registered nurse initiates a review and if</p>	<p>Interventions are not documented in the care plan for a) rest home resident re-</p>	<p>Ensure interventions are documented in</p>

<p>and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>required, GP, or nurse specialist consultation. There is documented evidence written on the family/whanau contact record of family notification when a resident health status changes including infections, incidents/accidents, GP visits, medication changes, care plan reviews, challenging behaviours, appointments and transfers. Three relatives (one dementia care, one psychogeriatric care and one hospital) interviewed confirm they are notified with any RN resident concerns and any significant events. They state the staff are very approachable if they wish to discuss their relative's health at any time and they are invited to the multidisciplinary (MDR) reviews.</p>	<p>commenced on protein drinks as per the written evaluation. The resident also experiences breakthrough pain as documented in the progress notes. There is no evidence of the GP being notified, or recorded monitoring of effectiveness on the lowa pain assessment form. The same resident is a high falls risk and requires regular toileting however this is not reflected in the care plan. b) One psychogeriatric resident with high falls risk does not have the wearing of hip protectors documented on the care plan. c) Risks associated with the use of enablers/restraints are not included in the assessment of two of three restraint/enabler files sampled. In three of three files sampled, risks associated with the use of enablers/restraints are not included in the care plan.</p>	<p>the care plans to reflect the residents current health status.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.