Bupa Care Servces NZ Limited - Tasman Care Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Tasman Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 October 2015 End date: 23 October 2015

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: 54

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 Tasman Care Home is part of the Bupa group of facilities. Tasman Care Home provides care for up to 72 residents across two service levels (hospital and rest home). Occupancy on the day of audit was 54 residents.

This certification audit was conducted against the Health and Disability Services Standards and the service's funding contract with the local district health board. The audit process included the review of documentation and resident files, observations and interviews. Interviews were conducted with management, staff, contracted general practitioner, residents and family/whānau to verify the documented evidence.

The new facility has been open since January 2015. Bupa systems and processes are being further established.

The service is managed by an experienced manager and she is supported by a clinical manager who has previous aged care and clinical training experience.

This audit identified improvements related to communication, implementation of the quality system, assessments and care planning, medication management system, access to activities programme, and staffing.

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

Tasman endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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 medium or high risk and/or unattained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes.

An organisational quality and risk management system supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. The first annual resident/relative satisfaction survey is underway and there are regular resident/relative newsletters. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

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

Registered nurses are responsible for each stage of service provision. The care plans are resident and goal orientated and reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months. There is two activities staff who implement the activity programme across the facility.

There are policies and procedures to guide staff in safe administration of medication. Medication charts are reviewed three monthly by the general practitioner. Residents' food preferences and dietary requirements are identified on admission and all meals are cooked on site. This includes consideration of any particular dietary preferences or needs.

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.

There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The building has a current compliance schedule and holds a current approved evacuation scheme.

Each resident room has either a shared ensuite or single ensuite. All ensuites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment. There is a large open plan lounge/dining area on each floor.

Appropriate training, information, and equipment for responding to emergencies is provided at induction and is included in the annual training programme. The call bell system is available in all areas with visual display panels.

There is one external courtyard/garden area and two floors have covered decks.

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.

Tasman Home and Hospital is restraint-free. There is one resident with an enabler. Enablers are voluntary and the least restrictive option. Staff have been provided with training around restraint and enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. The service engages in benchmarking with other Bupa facilities.

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	38	0	4	3	0	0
Criteria	0	86	0	4	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with six caregivers and two registered nurses (RNs) reflected their understanding of the key principles of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	The informed consent and resuscitation policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Completed resuscitation forms were evident on all resident files reviewed. There is evidence of general practitioner (GP) and family discussion regarding a clinically not indicated resuscitation status. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for daily cares. Enduring power of attorney evidence is sought prior to admission, medical competence assessment for activation EPOA is obtained, and both are kept in the resident's file. Caregivers interviewed (six) were familiar with the code of rights and informed consent and they described how

consent.		they implement choice and consent on a daily basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. This includes residents' visits to the local mall, visiting the library and attending community celebrations. There has been one resident/family meeting since the facility opened (link 1.1.9.1).
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation including follow up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are in a visible location at the entrance to the facility. Sixteen complaints have been received in 2015, the 11 most recent were reviewed with evidence of appropriate follow-up actions taken.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and RNs discuss aspects of the Code with residents and their family on admission. All eleven residents (seven rest home level and four hospital level) and five relatives (three rest home level, two hospital level) interviewed, report that their rights are being upheld by the service.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents' preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held each week. There is a policy on abuse and neglect and staff have received training.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There are currently two Māori residents living at the facility. Māori consultation is available through the documented Iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. The facility's residents are from a variety of cultures. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Services are provided at Bupa Tasman that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. These documents have been developed in line with 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. All Bupa facilities have a master copy of policies and procedures as well as related clinical forms. A number of core clinical practices also have education packages for staff, which are based on their policies. Bupa Tasman opened on 19 January 2015, when all Bupa systems were implemented. Registered nursing staff are available seven days a week, 24 hours a day. The general practitioner (GP) visits the facility at least three times a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site twice a week and there is a full-time physiotherapy assistant on site. There is a regular in-service education and training programme for staff. A podiatrist is onsite every six-weeks. The service has links with the local community and encourages residents to remain independent. Bupa has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. Tasman is benchmarked against the rest home and hospital data. The GP interviewed is satisfied with the level of care that is being provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	PA Low	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Twelve accident/incident forms were reviewed from September. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Shortfalls have been identified

communication.		around communication. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. 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. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Tasman Rest Home and Hospital is a Bupa residential care facility, which opened January 2015. The service has 72 beds and currently provides care for 54 residents at hospital and rest home level care. All beds are dual-purpose. On the day of the audit, there were 29 hospital level residents (including five interim care scheme residents), and 25 rest home residents. The service is divided across three floors with 24 beds on each floor. On level one there was one hospital resident, and eleven rest home residents (link 1.2.8.1). Level two included thirteen hospital (including the five interim care) and seven rest home residents. Level three included fifteen hospital and seven rest home residents. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. The care home manager is an RN with a current practising certificate who has worked in aged care for six years and facility management roles within Bupa. The manager has been in this role previous to opening. She is supported by a clinical manager who has worked at Bupa for 10 years and has been in the role of clinical manager at this service for the 9 months it has been open. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service. There is a regular review of the quality goals at the site and organisational level.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed	FA	The care home manager is supported by a clinical manager (RN) who is employed full time and steps in when the care home manager is absent for a day or two. If the care home manager is on leave, a Bupa relief care home manager covers with support from the regional manager.

in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	There is a quality and risk management programme. Interviews with the managers and staff reflect their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions have not always been established when required. Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a RN. Incidents are benchmarked and analysed for trends. The care home managers are aware of their requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human	FA	There are human resource policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed evidenced implementation of the recruitment process, employment

Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		contracts, completed orientation (for staff who were not new and still completing their orientation), and annual performance appraisals (for staff who were not new). Practising certificates are maintained in staff files. 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 (eg, RN, support staff) and includes documented competencies. New staff are buddied for a period of time. 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 Comps Level 3 unit standards. These align with Bupa policy and procedures. The service has 23 caregivers, six have completed level three, nine are enrolled in career force, and eight have been there less than 6 months. Bupa has a comprehensive annual education schedule. All staff are encouraged to attend at least 12 sessions a year, including compulsory sessions. There is an annual education and training schedule that is being implemented. Opportunistic education is provided via toolbox talks. The caregivers undertake aged Care Education (Careerforce). Education and training for clinical staff is linked to external education provided by the district health board. Five RNs are InterRAI trained. Four RNs have completed the Leading to Bupa 2020 Leadership course. A competency programme is in place with different requirements according to work type (eg support work, registered nurse, and cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. RN competencies include assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	There is an organisational staffing policy that aligns with contractual requirements. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged 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. The care home manager and clinical manager are RNs and share the on-call after hours. The care home manager and clinical manager are available during weekdays. RN cover is provided 24 hours a day, seven days a week on the two floors. The manager advised they are currently recruiting more staff and using agency staff to cover roster gaps and staff sickness. There are three separate units of 24 beds across three floors (each floor has their own nurses station). Each floor has dual service beds (rest home and hospital level care). Floor one has one hospital resident who is fully dependent and 11 rest home residents. Floor two includes 13 hospital level care (including five interim care scheme at hospital level funding) and seven rest home residents and floor three has 15 hospital and seven rest

		home level care residents. The clinical manager provides support (clinical oversite) across all three floors. There is one RN rostered on level two and one on level three on a morning, afternoon and night shift (although currently there was not consistently an RN rostered on an afternoon shift on both level two and three due to RN shortage).
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are kept secured. Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver, RN and other health professionals including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Resident's needs are assessed prior to entry and on entry to the service. The care home manager facilitates this and the required information related to entry to the service documented by the RNs. Residents interviewed (seven rest home and four hospital) stated they received an information brochure and were able to speak with the manager if they had any questions regarding the admission process. There is an admission policy, a resident admission procedure and a documented procedure for respite resident admission. The service provides services under the interim care scheme where residents enter the service for short-term stay after discharge from the local hospital. One (interim care scheme) resident file reviewed showed that care requirements were documented in the resident's file. An information pack is available for residents/families/whānau at entry and includes all required information. Residents and family members involved in the assessment process and files reviewed had multi-disciplinary meeting minutes signed by the family members. Admission agreement aligns with a) - k) of the ARC contract and all signed on the day of entry to the service. The admission agreement has been updated to include the addition of a new clause A6A.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a	FA	Policies related to death, discharge and transfer are implemented. A record and a copy of details are kept on the resident's file. Two resident files were reviewed for residents that had been transferred acutely to hospital. Transfer documentation was complete.

planned and coordinated transition, exit, discharge, or transfer from services.		
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 Moderate	The service uses four weekly robotic packs. Medication charts have photo IDs. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded are fed back to the supplying pharmacy. There is a list of standing-order medications approved by the contracted GP. Staff sign for the administration of medications on the medication sheet. The medication folders include a list of specimen signatures and competencies. Medication competent staff on level 1 and RNs on levels 2 and 3 are responsible for medication administration. Competency tests are completed annually. Three registered nurses have completed syringe driver competency. Medication error reporting occurs and staff completed medication management training. Medication policies align with accepted guidelines. Medications are stored in locked trolleys on each of the three levels. Controlled drugs are stored in a locked safe on each of the three levels and only the RNs have access to controlled drugs. A registered nurse from level two assists controlled drug administration on level one (link 1.3.6.1). Controlled drug checks are completed weekly. Self-administering of medications by residents is supported by the service. Two residents records reviewed showed that safe self-medicine administration is provided by the service. Residents' medicine competencies were checked and medication administration records were maintained. Medications were evidenced being stored securely in a locked drawer in the resident's' room. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. Shortfalls were identified around documentation on level one.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a six weekly rotating summer and winter menu. Bupa uses a national menu which has been audited and approved by an external dietitian. All food is cooked on site and delivered to rest home, hospital residents and serviced apartments with bain maries. There are five kitchen staff including two cooks and three kitchen assistants. All staff either obtained a food-handling certificate or commenced food safety training. Each floor has a locked kitchenette that has a servery out to the dining areas. Each kitchenette includes a servery area, fridge and dishwasher. Food is transported from the main kitchen to each kitchenette via a service lift. Kitchen fridge, food and freezer temperatures are monitored and documented daily, as per Bupa processes. Resident annual satisfaction survey includes food services and the 2015 survey results have not

		been analysed yet. Nutrition assessments are completed and weight monitoring occurs. Resident files reviewed included dietitian input. The resident's nutritional profiles are communicated to the kitchen and the cook interviewed was aware of resident's dietary requirements. Special equipment such as 'lipped plates' and built up spoons are available as required. Residents and families interviewed were very happy with food services.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	An admission information policy describes the declined entry to services process. The manager stated that they have not declined entry to the service to date, as they are a new provider and still have vacant beds. However, she is aware of recording requirements of the reason for declining service entry to residents, should this occur and will be communicated to residents/family/whānau and/or referred back to the referral agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Seven of eight resident files sampled (two rest home and five hospital), contain assessments including (but not limited to) pressure area risk assessment, falls assessment, pain assessment, skin assessment, continence assessment, behaviour assessment, and wound assessment (where appropriate). Assessments and support plans were comprehensive and included input from allied health. Five InterRAI competent RNs complete assessments (link 1.3.3.3). Notes by GP and allied health professionals are evident in residents' files. Significant events, communication with families and notes are documented as required by RNs. A written record of each resident's progress is documented. Resident changes in condition are followed-up by a registered nurse, as evidenced in residents' progress notes. When a resident's condition alters, the RN initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff stated they have all the equipment referred to in the care plans necessary to provide care.
Standard 1.3.5: Planning Consumers' service delivery plans are	FA	Six out of eight long-term care plans reviewed evidenced that interventions are fully recorded and align with the resident's assessed needs. One resident under the interim care scheme did not have documented evidence of implementation of identified interventions (link 1.3.6.1). The care plans reflect the outcomes of risk assessment

consumer focused, integrated, and promote continuity of service delivery.		tools. Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status. There is documented evidence of resident/family/whānau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process. Multi-disciplinary reviews included evidence of family participation in care planning.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Eight care plans reviewed evidenced that interventions were fully documented and aligned with the residents assessed needs. Implementation of interventions were not fully completed for two residents, including one resident under interim care scheme. Interview with one GP evidenced that the service can have access to medical services three times a week including one day on the weekend. The GP stated that he receives appropriate and timely referrals. Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Continence products are available and resident files reviewed included a urinary continence assessment, bowel management, and continence products identified for use. Specialist continence advice is available as needed and this could be described by the two RNs interviewed. The care staff interviewed stated that they have all the equipment referred to in the care plans and necessary to provide care. The clinical files sampled evidenced involvement of referral to allied health and specialist services as required. Physiotherapy assessment was evident in all residents file reviewed. The service employs a physiotherapy assistant who follows-up individual physiotherapy plans.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low	There are two activity coordinators, who have been employed in the last 10 weeks and one is a diversional therapist. The diversional therapist develops the activities programme and each resident receives a copy of the monthly plan. The plan is easy to read and printed in large type to assist those residents with who are visually impaired. Activities are planned that are appropriate to the functional capabilities of residents. All three levels provide dual services, however there is only one activity provided on one of the levels in the morning. In the afternoon, activities occur across two levels. Residents are required to be transferred one floor to another to access planned activities. Interview with residents, families and staff confirmed low participation in activities.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans are reviewed and evaluated by the RNs six monthly, or when changes to care occur. More frequent reviews were undertaken as residents care needs changed or after implementation of short-term care planning. Short-term care plans reviewed included wound care, infection and mobility. All short-term care plans reviewed, evidenced evaluation of the interventions and were signed and dated by the RN when issues had been resolved. Six caregivers interviewed stated they were informed of any changes to resident care. Staff are also informed of any changes to resident needs at handover between shifts.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the local need assessment agency, dietitian, mental health services, hospital specialists, physiotherapist and wound care specialist. The service provided examples of where a resident's condition had changed and the resident reassessed for a higher level of care. Discussions with the two RNs identified that the service has access to specialists as required. The service has an 'interim care contract'. Allied health input is available with physiotherapy input weekly, OT input as needed through the DHB. Dietitian and hospice advice as also available as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures in the management of waste and hazardous substances. There is a spill kit available for the facility. All accidents/incidents are required to be reported on the accident report form, which is in turn investigated by the manager and reported to the Bupa Health and Safety Coordinator. Material safety-data sheets are to be available in the sluice rooms on each floor. Each sluice room on each floor has a sanitiser. Advised that sharps containers are kept in the treatment room on each floor. A hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff.
Standard 1.4.2: Facility Specifications	FA	Tasman Care Home is a purpose built facility and currently has a compliance schedule dated 27 May 2015. The building has five floors. Administration, service areas and car parks on the ground floor and rest home and hospital level care is provided over levels 1, 2 and 3. Each floor has 24 beds, nurses' station,

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		medicine/treatment room and combined lounge/dining. A lift between floors is large enough for a stretcher bed and there is stair access. There is also a service lift available. Residents are able to bring their own possessions into the home and are able to adorn their room as desired. The maintenance schedule includes checking of equipment. A maintenance person works eight hours a week and is also available on request. All electrical equipment is checked and tagged. There are handrails in the ensuites, communal bathrooms and hallways. All rooms and communal areas allow for safe use of mobility equipment. The facility is carpeted throughout with vinyl surfaces in bathrooms/toilets and kitchen areas. There is adequate space on each floor for storage of mobility equipment. Landscaping has been completed and residents have access to the courtyard and deck area. Environmental audits and building compliance audits are completed as part of the internal audit programme. There is a planned maintenance programme to ensure all buildings, plant and equipment are maintained.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All three levels have a mobility toilet near the lounge. Each resident room has either a shared ensuite or single ensuite. All ensuites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment. Shared ensuites have locks and green/red lights to identify whether or not it is occupied. Staff can open these in an emergency, if necessary. There is a mobility bathroom with a shower bed on each level.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents rooms on all three levels are large and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and communal toilets/bathrooms in all areas. Residents requiring transportation between rooms or services can be moved from their room by stretcher, lazy boy or wheelchair.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is an open plan lounge/dining area on each level. The facility has a whānau room and a small library that can be used by relatives and residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures around management of laundry and cleaning services. The laundry service is outsourced. All laundry is transported for laundering daily. There are areas for storage of clean and dirty laundry on the ground floor. There are separate cleaning staff and each floor has a sluice room. Cleaning and laundry services are monitored for effectiveness. The last cleaning/laundry audits were completed in July 2015. Cleaning services required a follow-up audit and this was completed in a timely manner. Chemicals are stored securely. Staff received training around chemical safety.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate training, information, and equipment for responding to emergencies is provided at induction and as part of the annual training programme. Staff training in fire safety is completed and fire drills take place six monthly. There is a comprehensive civil defence manual and emergency procedure manual in place. Civil defence kits are stored on each floor by the nursing station. There is a staff member on each shift with a first aid certificate. The fire evacuation plan is signed off as approved by the fire service (24 November 2014). The facility has torches to be used as emergency lighting. There is a portable generator access point in the front door of the building. Emergency water is stored in the car park on the ground floor and the care home manager stated that emergency water is also stored at the ceiling space of the building. Gas BBQ and additional cylinders are available for alternative cooking. An emergency food supply sufficient for three days is kept in the kitchen. Extra blankets are also available. The call bell system is available in all areas with visual display panels. Call bells are available in all resident areas that is, bedrooms, ensuite toilet/showers, communal toilets, dining rooms. The call bell system is connected to staff pagers. The home care manager monitors staff response to residents call bells, as required. There is a two-door entrance to the lobby, which is open 24 hrs a day. The front door access into the care home locks at 5 pm and unlocks at 7 am. Afterhour's access is by way of keypad for staff and an intercom to the nurse call station, where they can unlock the doors during this time. Anyone can leave anytime from the inside during

		these hours by pushing the exit button. The facility has a contract with a security firm, which provides overnight checks and staff are able to access them if required.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Tasman Care Home is appropriately heated and ventilated. There are ceiling heaters in resident rooms and ceiling heat pumps in hallways and lounge areas. There are heat control panels in individual rooms. There is plenty of natural light in the new rooms and all have windows. The maintenance person monitors room temperature, ensuring that an even and comfortable temperature is maintained. Tasman Care Home is a smoke free facility. No staff, residents and visitors are allowed to smoke in the facility or Tasman Care Home grounds.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme is appropriate for the size and complexity of the service. The IC programme is implemented and has been linked to the quality programme. There is a job description for the infection control (IC) coordinator and clearly defined guidelines. The infection control committee is active and IC matters discussed at the staff and quality meetings. The IC programme is reviewed annually at the Bupa office. The facility has developed links with the GP, local laboratory and public health authorities. IC audits have been conducted and education has been provided for staff.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Tasman Care Home. The infection control committee is made up of a cross section of staff from all areas of the service and meet two monthly. External resources and support are available when required. The IC coordinator is supported by the Bupa office through the regional IC group. Infection prevention and control is part of staff orientation and induction.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly, by Bupa.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The clinical manager is the infection control coordinator and she is responsible for coordinating/providing education and training to staff. She completed IC training in September 2015, and is suitably skilled and trained to manage infection prevention and control matters. She facilitates IC training for all staff and staff interview confirmed current knowledge around IC practices. Staff also described the most recent suspected outbreak and training provided following that. The orientation package for new staff includes specific training around hand washing and standard precautions. Residents care plan included infection control practices around MRSA and ESBL.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. The IC 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. Infections are included on a monthly register and a monthly report is completed by the IC coordinator. Infection control data is collated monthly, and is reported at the quality and staff 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

specified in the infection control programme.		infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. A suspected infections outbreak was reported to the public health authorities in October 2015. Interview with staff and document review confirmed that appropriate infection control and management practices were implemented. Infection control data is benchmarked against other Bupa facilities and shows higher infection trends. Document review shows discussions of these results with staff and recommended corrective actions from the Bupa Office have been implemented.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had no residents using restraint and one resident with bedrails as an enabler documented. All enabler use is voluntary. The restraint/enabler assessment form was completed, with input from the RN and GP and the resident's family and this was documented in the file of the resident who was using an enabler. There are clear guidelines in the policy to determine what a restraint and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

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)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	1. Ten of twelve incident forms reviewed identified family notification. 2. There has been one resident/family meeting minuted since the service opened. 3. Three of five families interviewed were happy with the communication from the service.	(i)Two of twelve incident forms reviewed did not have family notification identified. (ii) Residents meetings have not taken place as per policy. (iii) Two of five families interviewed stated the communication with them was inadequate.	(i) Ensure family are notified of incidents as per policy. (ii) Facilitate resident and family meetings as per policy. (iii) Ensure families receive appropriate and timely communication. 90 days
Criterion 1.2.3.8	PA Low	Monthly clinical indicator data is collated across the facility, monitoring rest home	Corrective action plans have not been routinely developed where benchmarking data exceeds	Ensure corrective action plans are

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.		and hospital services. There is evidence of trending of clinical data, but limited development of CAPs when volumes exceed targets (eg, falls). Meeting minutes and internal audits identify corrective actions.	targets.	implemented from analysis of benchmarking data/trends. 90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	There is an organisational staffing policy that aligns with contractual requirements. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged 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. Two of five families interviewed had staffing concerns. Residents interviewed were happy with staffing levels. A clinical manager (currently on leave) and care home manager (RN) work full time. A RN is rostered on level three daily on a morning and night shift and on an afternoon shift as RN staff are available. On level two, a RN is rostered across the three shifts, although this is not consistent. However, there is always one RN rostered 24/7 across the facility. The service provides dual service across the three floors and interviews and documentation reviewed identified shortfalls around the accessibility of a RN on floor one when needed.	The service provides dual services across three floors. Currently on the first floor, there is one hospital resident and 11 rest home residents. There are two caregivers rostered on morning, two on the afternoon and one at night. There are three hours after lunch when there is only one caregiver. Caregivers interviewed stated they have to access a RN from the floor above or the clinical manager when needed. Interviews identified that RNs are not always available when needed due to work commitments on their floor. The hospital level care resident on level one requires two staff support and regular 'prn' controlled drugs (also link 1.3.6.1).	Due to the layout of the facility (three levels) and the acuity of the residents, staffing levels need to be reviewed to meet individual resident's needs. 60 days

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 Moderate	The facility uses the robotics medication management system. The RNs check the delivery and the pharmacist is informed of any discrepancies. The facility's medication policies and procedures cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation. They follow recognised standards and guidelines for safe medicine management practice. Eighteen medication charts were reviewed across the facility and all 18 medication charts have photographic identification of the resident and medicine allergies were documented or recorded as “nil known’ as appropriate. There is a locked fridge in all three areas and fridge temperatures are being monitored.	The following shortfalls were noted on level 1. (i) Short course medication was prescribed for five days, but only documented as administered for one day. (ii) As required medication was being administered for six weeks on a regular basis. Although the GP visit occurred during this time, a medication review was not completed. (iii) Non-packed regular medication was not always signed as given.	(i) Ensure that medications are administered as prescribed. (ii) Ensure that ‘prn’ medications are reviewed if they are administered regularly. (iii) Ensure that medications are signed as administered and reason for non–administration is recorded. 30 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Three out of eight files reviewed evidence that each stage of service provision has been provided within timeframes identified by service policies and procedures and ARC contract. Five of eight files did not have InterRAI assessments and/or care plans completed within required timeframes.	(i) Two residents admitted to the service after 1 July 2015 did not have an InterRAI assessment. (ii) One hospital resident was admitted on 21 August and the first InterRAI assessment was completed on 9 October. (iii) Two hospital resident’s did not have a care plan completed within 21 days.	Ensure that InterRAI assessments and nursing care plans are completed within required timeframes. 90 days

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 Moderate	Eight care plans reviewed evidenced that interventions were fully documented and aligned with the residents assessed needs. Implementation of interventions were not fully completed for two residents, including one resident under interim care scheme. Interview with one GP evidenced that the service can have access to medical services three times a week including one day on the weekend. The GP stated that he receives appropriate and timely referrals. Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Continence products are available and resident files reviewed included a urinary continence assessment, bowel management, and continence products identified for use. Specialist continence advice is available as needed and this could be described by the two RNs interviewed. The care staff interviewed stated that they have all the equipment referred to in the care plans and necessary to provide care. The clinical files sampled evidenced involvement of referral to allied health and specialist services as required. Physiotherapy assessment was evident in all residents file reviewed. The service employs a physiotherapy assistant who follows-up individual	(i) One resident file under the interim care scheme was reviewed. The resident was admitted to receive short-term hospital level care and the care plan was developed prior to entry by the referring agency. The care plan included the instruction to complete daily neuro observations and daily monitoring of vital signs. A review of documents identified that neuro observations were recorded four days after admission and there were documented gaps between recordings of three to four days. Vital signs were not recorded daily. (ii) One hospital level care resident had several falls recently and the most recent two falls resulted in injuries. Staff interview confirmed that the resident is often in pain, but they have to wait on an RN from the floor above to be available to assess the resident and administer pain relief (also refer 1.2.8.1). A review of progress notes identified that the resident did not always receive pain relief medication in a timely manner.	Ensure that care plan interventions are implemented. 60 days

		physiotherapy plans.		
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	The two activity coordinators (employed in the last 10 weeks) provide activities across the care centre 5 days a week. One works full time, the other between 1.30 pm and 5 pm. The activities are provided in the lounge or dining areas and one-on-one activities are provided in the residents rooms. The programme is developed monthly and displayed in large print. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. The programme includes networking within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is fed into the resident's care plan and this is reviewed six monthly as part of the lifestyle care plan review/evaluation. A record is kept of individual residents activities. Each resident has a 'map of life'. The resident/family/whānau as appropriate is involved in the development of the activity plan. Two of five family members interviewed reported there needed to be more activities. Staff interview confirmed that they need to assist activities coordinators to transfer the resident where the activities occur and this is not	Currently the activities programme is provided on one level in the morning and across two levels in the afternoon. To access activities, residents at times are required to be transferred one level to another. Interview with staff confirmed that this has not always been facilitated due to staff commitment to provide resident care first.	Revise the activities programme across the three floors to ensure a more easily accessible programme. 180 days

		always done due to their other work commitments. One rest home and one hospital resident commented on lack of activities however, six rest home and three hospital residents interviewed were happy with the activities provided.		

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.