

# Bupa Care Services NZ Limited - Glenburn Rest Home & Hospital

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## 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:** Glenburn Rest Home & Hospital

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 23 February 2016      End date: 24 February 2016

**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:** 102

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Glenburn Rest Home and Hospital is part of the Bupa group. The service is certified to provide hospital (medical, geriatric); psychogeriatric, rest home and dementia level care for up to 104 residents. On the day of the audit there were 102 residents.

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

The care home manager and clinical manager at Glenburn have been in their respective posts for a number of years. The care home manager has many years' experience in aged care and management. There are systems being implemented that are structured to provide appropriate quality care for residents. An orientation and in-service training programme continues to be implemented that provides staff with appropriate knowledge and skills to deliver care. Residents and family advised that the staff provide a caring and homely environment.

The service is commended for achieving two continued improvements ratings related to implementation of quality initiatives/outcomes and good practice.

This audit identified an improvement required around discussing not for resuscitation orders with families.

## 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.

Glenburn endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan supporting practice. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code of Rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with the community.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Glenburn is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Quality and risk performance

is reported across the facility meetings and to the organisation's management team. Quality initiatives are implemented which provide evidence of improved services for residents. There are four benchmarking groups across the organisation focusing on rest home, hospital, dementia, and psychogeriatric/mental health services. Glenburn is benchmarked in all of these. There are human resources policies to guide practice and an 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. 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.		Standards applicable to this service fully attained.
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. 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. The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings, and celebrations. Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on site. Snacks are available.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. There are an adequate number of shower and toilet facilities for the number of residents. The dementia and psychogeriatric units are secure and provide a safe homelike environment for residents. There is wheelchair access to all areas. External areas are safe and well maintained with shade available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

## 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 restraint and included in the policy. The service has eight residents on the register with restraint and no enablers. Restraint includes bedrails and seating restraint. 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 restraint competencies are completed regularly.

## 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 officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer is supported by the Bupa quality and risk team. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive on-going training in infection control.

## 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)
<b>Standards</b>	2	47	0	1	0	0	0
<b>Criteria</b>	2	98	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Bupa policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents have been provided with information on admission which includes the Code. Staff have received training about the Code and competency questionnaires are also completed. Interviews with seven caregivers (one rest home, two dementia/psychogeriatric and four hospital), one enrolled nurse and five registered nurses demonstrate an understanding of the Code. Seven rest home and five hospital residents and six relatives (two hospital, two rest home, one dementia and one psychogeriatric) interviewed confirm staff respect privacy, and support residents in making choices where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	PA Low	<p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident on all resident files reviewed. Two of the eleven files sampled had clinically indicated not for resuscitation status signed by the general practitioner (GP) but there was no documented evidence that this had been discussed with the resident/family. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms etc. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed with the admission agreements.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code and information about advocacy services on entry. Interview with the care home manager and the clinical manager confirmed this occurs. Interview with residents confirmed that they are aware of their right to access advocacy. Interview with family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the files reviewed there was information on residents' family/whanau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	The activities policy encourages links with the community. This was seen to be implemented at Glenburn with the activities programmes including opportunities to attend events outside of the facility. Residents and relatives interviewed informed visiting can occur at any time, and that the service encouraged involvement with community activities. Visitors were observed coming and going at all times of the day during the audit.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	There is a complaints procedure to guide practice. The care home manager has overall responsibility for managing the complaints process at Glenburn. A complaint management record has been completed for each of the five complaints received in 2015 and a record of all complaints per month had been recorded on the register. The register included relevant information regarding the complaint including date of resolution. Verbal complaints are included and actions and response are documented. Complaints are reported to head office monthly. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. Discussion with residents and relatives confirmed they were provided with information on the complaint process. Complaint forms were visible for residents/relatives in various places around the facility. There has been one anonymous complaint to the Ministry of Health in 2015 which was not substantiated.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. There is the opportunity to discuss these services prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed in the facility. The families and residents have been informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. The monthly resident/relative newsletter and MDT meetings also provide the opportunity to raise issues/concerns. Residents and relatives interviewed confirm information has been provided around the Code and the complaints

		process.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Ten resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and then integrated with the residents' care plan. There was evidence of family involvement. A tour of the facility confirmed there is the ability to support personal privacy for residents. There is an abuse and neglect policy which is being implemented and includes staff in-service education.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Bupa has a Maori health plan that aligns with contractual requirements. There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Bupa Maori health policy was first developed in consultation with Kaumatua and is utilised throughout Bupa's facilities. Family/whanau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values,</p>	FA	<p>The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau. Values and beliefs have been discussed at the initial care planning meeting and then incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>

and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The Code of Conduct is included in the employee pack. Job descriptions include responsibilities of the position and are in files reviewed. There are implemented policies to guide staff practice in respect of gifts. Clinical meetings occur two monthly and include discussion on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the clinical manager and five registered nurses confirmed an understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Services are provided at Glenburn that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. All Bupa facilities, including Glenburn, 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. There are four benchmarking groups monitored across Bupa, of which Glenburn is benchmarked against rest home, dementia, hospital and psychogeriatric indicators. Information is provided to staff on the trends and corrective action plans when indicators are above the benchmark (e.g. skin tears, falls). Actions were reviewed and signed out. Bupa quality and risk management systems are being implemented at Glenburn. All caregivers are required to complete foundations level two as part of orientation. Bupa has introduced leadership development of qualified staff including education from HR, attendance at external education, Bupa qualified nurses' education day and education sessions at monthly meetings. There are implemented competencies for caregivers, enrolled nurses and registered nurses. The standardised annual education programme, core competency assessments and orientation programmes were all seen to be being implemented at Glenburn. There is a Bupa "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). This continues to be implemented at Glenburn.</p> <p>Further examples of good practice at Glenburn include:</p> <p>Glenburn Rest Home and Hospital has an experienced management team with many years' experience in the aged care industry. 50% of the current staff (100) have worked at Glenburn for five years or more and of those 50 staff, 50% have worked at Glenburn more than 10 years. This provides Glenburn with a family feel that residents and families appreciate and reported on when interviewed.</p> <p>The service has refurbished several rooms in the rest home and created space so that they now have a dedicated meeting/education room. Glenburn has enhanced the lounges in the dementia and psychogeriatric unit by painting the walls red and in another lounge they have coloured the walls blue. It has given the lounges more warmth and atmosphere. To enhance outdoor areas white planter boxes have been purchased and filled with flowers. They have also purchased new outdoor furniture and are awaiting the installation of another shade sail.</p>

		<p>The care home manager visited the local marae in 2016 to establish a good relationship and they plan to organise a marae visit for our staff as many have never been to one.</p> <p>Pharmacy reviews by the WDHB pharmacist occur, looking mainly at poly-pharmacy</p> <p>There are six-weekly meetings with Mental Health for Older Adults Psychiatrist, Nurse and Pharmacist</p> <p>Staff progress is reported at the staff meetings. Discussions with residents and relatives were positive about the care they receive.</p> <p>The service has exceeded the required standard around good practice by focussing on staff competence, team work and communication.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an incident reporting policy to guide staff on their responsibility around open disclosure. Incident forms reviewed identified that family had been notified following a resident incident. Relatives stated that they are informed when their family members health status changes. There is an interpreter policy and contact details of interpreters were available. 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 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. The information pack is available in large print and this can be read to residents. Information specific to the psychogeriatric and dementia unit is provided to family on admission.</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>CI</p>	<p>Glenburn is a Bupa facility which provides hospital, rest home, dementia and psychogeriatric level care for up to 104 residents. Occupancy on the day of audit was 102 residents. Twelve dementia residents and thirteen psychogeriatric residents live in the two separate wings of the secure Koru unit including one dementia level resident on respite care and one psychogeriatric level resident on a long term chronic conditions contract. Fifty residents in the Manuka rest home wing and fifty residents live between the two hospital wings (Rata and Kowhai), including three on young persons with disabilities contracts, one on short term respite care and one on a long term chronic conditions contract.</p> <p>The philosophy of the service includes providing safe and therapeutic care for residents requiring specialised hospital level care (psychogeriatric), dementia care, rest home care and hospital care. Bupa have identified six key values that are displayed on the wall at Glenburn. There is an overall Bupa business plan and risk management plan and a documented purpose, values, and direction. Each facility is required to develop annual quality goals – one of the goals Glenburn had been focusing on reducing the incidence of challenging behaviour by 50% across the 2015 year. Progress towards goals were reported through the various meetings – for example the quality meetings, unit meetings and clinical meetings. The service has exceeded the required standard around using quality goals to improve outcomes for residents. Glenburn participates in the organisations</p>

		<p>benchmarking programme that monitors key aspects of care.</p> <p>The care home manager at Glenburn is an experienced manager (RN) who has managed the facility for the past nine years. She is supported by a clinical manager (registered nurse) who oversees clinical care and has also been in the role for many years. The management team is supported by the wider Bupa management team that includes an operations manager. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six monthly. The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the clinical manager provides cover for the manager's role, supported by the operations manager. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</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>	FA	<p>Glenburn continues to implement the Bupa quality and risk management system which is designed so that key components are linked to facility operations. The quality committee meet two monthly and outcomes are then reported across the various other meetings. Meeting minutes reviewed include discussion about the key components of the quality programme.</p> <p>Policy review is coordinated by Bupa head office. The service has comprehensive policies/procedures to support service delivery including a policy around meeting interRAI requirements. The quality programme includes an annual internal audit schedule that was being implemented at Glenburn. Audit summaries and corrective action plans (CAPs) are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee e.g. quality, health and safety. CAPs are seen to have been implemented and closed out. Monthly and annual reviews are completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings are held.</p> <p>The service has a health and safety management system. There are implemented risk management and health</p>

		and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
<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>	FA	Glenburn collects incident and accident data on the prescribed form. Forms reviewed had been completed comprehensively, reviewed by the clinical manager and signed off. Monthly analysis of incidents by type has been undertaken by the service and reported to the various staff meetings. Data was linked to the organisation's benchmarking programme and used for comparative purposes. CAPs were created when the number of incidents exceeded the benchmark – e.g. bruising. CAPs were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification was made following an event in August 2015 and Public Health was notified in August 2015 of a well contained gastro outbreak.
<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>	FA	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed and included all appropriate documentation. Staffing levels are stable with some staff having been employed for a number of years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. There was a completed in-service calendar for 2015 which exceeded eight hours annually. The service has made improvements to staff attendance at training by the implementation of new initiatives (link 1.1.8.1). Caregivers have completed either the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme. There are a total of 12 caregivers who work in the dementia and psychogeriatric units. Ten of these have completed the required NZQA dementia standards. The other two have been working there for less than three months. The clinical manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local DHB.

<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 that aligns with contractual requirements. 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 a minimum of two registered nurses plus care staff on every shift. This includes one registered nurse in the psychogeriatric unit at all times (who also covers the dementia unit when required) and at least two registered nurses in the hospital 24 hours per day (who provide cover to the rest home). The dementia unit and psychogeriatric unit have a shared office with windows into the lounge of each unit and are connected with call bells alerting through both services. Interviews with caregivers from across all units inform the nursing staff and management are supportive and approachable. Staff interviewed informed there is sufficient staff on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in locked cupboards. Care plans and notes were legible and where necessary signed and dated by a registered nurse. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered at admission is retained in resident's records. The service has well-developed information packs available for residents/families/whanau at entry including short term stay. Advocacy is available if appropriate. The admission agreement reviewed meets the requirements of the ARC and ARHSS contracts. Eleven admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	<p>FA</p>	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering medications on the day of audit. Both had a current competency assessment. There is a locked medication room for each unit. All medications were securely and appropriately stored. The facility uses a robotic pack system. In the rest home and dementia unit, registered nurses or senior caregivers who have passed their competency administer medications. In the hospital and psychogeriatric units all medications are administered by RN's. Medication competencies are updated annually and include syringe drivers. Medication charts have photo identification. 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 that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines and this was documented and up to date in all 22 medication signing sheets reviewed. The medication folders include a list of specimen signatures and competencies.</p> <p>Medication profiles reviewed were legible, up to date and reviewed at least three monthly by the GP. All 22 medication charts reviewed have 'as required' medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges.</p>
<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>	<p>FA</p>	<p>The service employs one head cook and three cooks whose shifts rotate as well as one kitchen hand who works a split shift. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals are cooked onsite. Meals are delivered to the units in bain marie's.</p> <p>On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. The head cook also monitors the fridges in the small unit kitchens. These were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets were noted on the kitchen notice board which is able to be viewed only by kitchen staff. The national Bupa menus have been audited and approved by an external dietitian. Residents and families interviewed were generally very happy with the meals provided. There was evidence that</p>

		there are additional nutritious snacks available over 24 hours.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Bupa assessment booklets and long term care plans reviewed were comprehensively completed for all eleven resident files reviewed. The assessment booklet provides in-depth assessment across all areas of care. Risk assessments are completed on admission and reviewed six monthly as part of the support plan review. Additional assessments for management of behaviour, wound care and restraint were appropriately completed according to need. For the eleven resident files reviewed, InterRAI assessments and Bupa risk assessments were in place and they linked to the care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans reviewed were comprehensive and multidisciplinary. All eleven resident care plans were resident centred and documented in detail support needs. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Long term care plans in the dementia and psychogeriatric units detail care and support for behaviours that challenge, including triggers, associated risks and management. Short term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. There was evidence of service integration with documented input from a range of specialist care professionals. Psychogeriatrician support and advice is documented.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	FA	All eleven care plans reviewed included documentation that meets the need of the residents and all care plans had been updated as residents' needs changed. Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members and residents interviewed confirmed that the clinical care is of a high standard and that they are involved in the care planning.

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Caregivers and RNs interviewed state there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms were in place for the current wounds being managed. There were nine skin tears, one cyst, two small skin lesions and one leg ulcer (not chronic). Registered nurses could describe accessing a wound nurse specialist when needed.</p> <p>Monitoring charts are well utilised where required including behaviour monitoring charts. Any resident at risk of pressure injury is turned regularly and they do use turning charts if necessary. All residents are weighed monthly. If there is a weight loss or gain trend there is discussion with the G.P and/or a referral to a dietitian.</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>There is one activities coordinator (20 hrs weekly) and two activities assistants, (38 and 30 hrs weekly). All three have completed dementia training. A physiotherapy assistant assists with walking and exercise groups. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The Bupa activities programme template is designed for high end and low end cognitive functions and caters for individual needs. The programme is developed monthly and displayed in large print and colourful illustrations. Residents have an assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. The residents' activity care plans have de-escalating techniques for residents with behaviour that might challenge. Church groups visit weekly. There are van outings twice weekly. Events such as birthdays, Easter, Mother's Day etc. are celebrated. Younger residents are encouraged and supported to attend community events/groups.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were evaluated by the registered nurses six monthly or when changes to care occurs. Short term care plans for short term needs were evaluated and either resolved or added to the long term care plan as an on-going problem. The multidisciplinary review involves the RN, GP, activities staff, resident/family and clinical manager. The family are notified of the review by email and if unable to attend they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner with residents in the hospital being seen monthly. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for</p>	<p>FA</p>	<p>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. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the RN's identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services.</p>

access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are comprehensive and up to date policies that include chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas in all services. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The maintenance person described the safe management of hazardous material.</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>	FA	<p>The building holds a current warrant of fitness which expires on 23 September 2016. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Hoists and scales have been tested and tagged. Reactive and preventative maintenance occurs. There is a 52 week planned maintenance programme in place. Hot water temperatures have been monitored monthly in resident areas and were within the acceptable range. The living areas and hallways are carpeted but the bedrooms have vinyl surfaces as do bathrooms/toilets and kitchen areas. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. The psychogeriatric and dementia unit are secure from the rest of the facility. Each unit has their own secure external courtyard. The facility has a van available for transportation of residents. The staff transporting residents hold a current first aid certificate. In the facility, residents are able to bring in their own possessions and are able to personalise their room as they wish. There are quiet, low stimulus areas that provide privacy when required.</p>
Standard 1.4.3: Toilet, Shower, And Bathing	FA	<p>There are adequate toilets and showers in the rest home, hospital, dementia and psychogeriatric units. Resident rooms in the rest home, dementia and psychogeriatric units have hand basins. In the upstairs hospital unit all</p>

<p>Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>rooms have a shared en-suite between two residents. In the downstairs hospital unit residents' rooms have toilet en-suites and hand basins. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There are sufficient numbers of communal toilets and mobility bathrooms. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Communal toilets and bathrooms have appropriate signage and locks on the doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents' rooms in the rest home unit are slightly smaller but still of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents' rooms in all other areas are larger. Mobility aids can be managed in ensuite facilities. The lounge areas are spacious and can be used for activities and small groups as well as for private social interaction. There are smaller lounges for residents who prefer quiet, low stimulus areas. Residents requiring transportation between rooms or services are able to be moved safely from one area to another. Staff interviewed reported that they have adequate space to provide care to residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Activities occur throughout the facility in the lounge areas. The lounges are all large enough to not impact on other residents who are not involved in activities. Seating and space is arranged to allow both individual and group activities to occur. There are small lounges/dining areas where residents who prefer quiet low stimulus areas may sit. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site. The laundry is small but well organised and is divided into a “dirty” and “clean” area. Staff interviewed state that they manage the workload adequately. There are appropriate systems for managing infectious laundry which laundry staff could describe. There is a comprehensive laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system and the resident satisfaction surveys. The cleaners trolleys were attended at all times or locked away in the cleaning rooms as sighted on the day of the audit. There is a sluice room in each part of the facility for the disposal of soiled water or waste. These and the laundry are kept locked when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs were in place. The service has alternative gas facilities for cooking in an event of a power failure with a backup system for emergency lighting and battery backup. Oxygen cylinders are available. There is a civil defence kit in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility has plenty of natural light. There is underfloor heating in all areas except the rest home where there are panel heaters. Smoking is only allowed outside in a ‘smoking’ courtyard. There is currently only one smoker. Apart from this the facility and grounds are a smoke free area.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and the description of the infection control programme are available. There is a job description for the infection control (IC) coordinator and clearly defined guidelines. The infection control</p>

<p>environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>programme is linked into the quality management programme. The infection control committee meets bimonthly at Glenburn. The quality meetings reviewed also included a discussion of infection control matters. The IC programme is reviewed annually at head office. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. Bupa have a regional infection control group (RIC) for the three regions in NZ.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control committee is made up of a cross section of staff from all areas of the service. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. There is also a 'scope' of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases. Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to staff. The IC coordinator (clinical manager) is suitably skilled and trained to manage infection matters. The orientation package for new staff includes specific training around hand washing and standard precautions. There has been infection control training provided as part of the annual education schedule. Tool box sessions are also used opportunistically to maintain staff knowledge. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes 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. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the IC coordinator. 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. 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>	FA	<p>There is a regional restraint group at an organisation level that reviews restraint practices. The Glenburn quality committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what is restraint and what is an enabler. The restraint policy includes comprehensive restraint procedures. There are no residents with enablers. There were a total of eight residents on restraint. This includes four hospital residents with bed rails, two with t-belts, one with a lap belt and one psychogeriatric resident who uses both a lap belt and a bedrail. All restraint use is recorded on a restraint register. Files for four residents with restraint were reviewed. All files evidenced that a documented three monthly review of restraint has been conducted. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, regional restraint meetings and at an organisational level.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	FA	<p>The restraint coordinator is the clinical manager (registered nurse). The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions included the restraint coordinator, clinical manager, registered nurses, resident/or family representative and medical practitioner.</p>

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		Restraint use and review is part of the quality team meeting.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, clinical manager, registered nurses, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. Assessments and approvals for restraint were fully completed. These were sighted in the four files reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are followed. There is an assessment form/process that was completed for all restraints. The four files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. Consent forms detailing the reason and type of restraint were completed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register which had been updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the four restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices were reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings. Evaluation timeframes were determined by risk levels.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews were completed three monthly or sooner if a need is identified. Reviews were completed by the restraint co-ordinator. Any adverse outcomes were included in the restraint co-ordinators monthly reports and were reported at the monthly meetings. Restraint use is reviewed as part of the quality team meeting</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 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p>	PA Low	There is a policy in place for informed consent and resuscitation. General consent forms were evident on files reviewed. Completed resuscitation treatment plan forms were evident on all resident files reviewed and nine of eleven of these evidenced discussion with families around GP initiated resuscitation orders.	Two of the eleven files sampled had clinically indicated not for resuscitation status signed by the G.P but there was no documented evidence that this had been discussed with the EPOA/family.	<p>Ensure all resuscitation plans with a clinically not indicated resuscitation status have documented evidence of discussion/input with the EPOA/family.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Bupa has a number of practices to enhance good practice and these are implemented at Glenburn. Practices include prioritising staff training including external training for registered staff and having an accredited PDRP programme for registered nurses. The service engages in benchmarking for each of the service levels at Glenburn and comprehensive corrective action plans are developed whenever a trend is identified or an area is outside the benchmark. The corrective action plans are implemented and evaluated with benchmarking results improving in most</p>	<p>In 2015, Bupa Glenburn developed a goal to improve staff satisfaction. Therefore the service provided to residents by engaging staff in a more interesting and positive training and providing team building exercises. The service had previously not provided specific team building exercises and had providing staff training in a rotating manner in the afternoon on an allocated day (or more) each month. Staff enthusiasm for training had dwindled, in part due to the very long standing staff at the service. Staff training/team building days were planned with the days being offered five times in 2015 to allow as many staff to attend as possible.</p> <p>A room was booked off site that provided a nice atmosphere, a meal and morning and afternoon tea were catered. Compulsory trainings were covered with a variety of team building exercises included. The training database showed an increase in staff attendance at training in this format compared to previous years. Staff interviewed reported that the ‘training days’ were stimulating and enhanced the team atmosphere with tangible results, including</p>

		cases.	better communication between staff and better team work. Staff survey results in 2015 reflected this. Residents and family interviewed all commented positively on staff and team work and staff attitude was frequently mentioned without prompting. The 2014 resident/relative satisfaction survey had very positive results. Despite the 2014 results scoring in the excellent range, the results of the 2015 resident /relative satisfaction survey results showed an increase in satisfaction around respectfulness of staff, quality of care, staff knowing residents and meeting their needs, consistency of staff and overall rating of the care home.
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Each Bupa facility develops annual quality goals specific to the service which have timeframes and are measurable. Glenburn's goals for 2015 included increasing the score for recognition and performance by 4%, reducing bruising by 10%, no medication errors, facility presentation audit scores above 95% and reducing challenging behaviours by 50%. Progress toward goals is reviewed regularly and goals for 2016 have been developed and plans to achieve these developed.</p>	<p>Each year Glenburn develops a set of quality goals for the service that complement the Bupa strategic goals. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Glenburn and forwarded to the Bupa quality and risk team. Meeting minutes reviewed included discussion around ongoing progress to meeting their goals. Glenburn annual goals link to the organisation's goals and this is reviewed in quality meetings and also in each of the unit/other meetings. This provides evidence that the quality goals are a 'living document'.</p> <p>An example of quality goals being used to improve outcomes for residents is the 2015 goal to reduce challenging behaviour incidents. A plan that included ensuring all registered nurses completed the Career Force dementia unit standards (in addition to the compulsory completion by caregivers working in the dementia and psychogeriatric units) and de-escalation training for staff. A new protocol developed with the Mental Health Service for Older People around supporting residents with behavioural and psychological symptoms of dementia was implemented. Progress was discussed in monthly meetings and formally documented quarterly. Further interventions were identified and implemented in response to progress made. As a result of the focus on this quality goal, reported incidents of challenging behaviour decreased by 43% between 2014 and 2015.</p>

End of the report.