Bupa Care Services NZ Limited - Cornwall Park Hospital

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:	Cornwall Park Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)
Dates of audit:	Start date: 18 May 2015 End date: 19 May 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: 38

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

Cornwall Park Hospital is part of the Bupa group. The service provides psychogeriatric level care for up to 39 residents. On the day of the audit there were 38 residents.

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

The service is currently managed by an experienced relieving manager from another Bupa facility (specialising in psychogeriatric level care). The facility manager is supported by a relieving clinical manager (CM) from the Bupa Quality & Risk team.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

Improvements are required around the quality management system, hazard register, incident/accident documentation, care plan timeframes, care plan interventions, short term care plans, medication documentation, chemical management, maintenance, locked exit doors, cleaning and outbreak documentation.

Consumer rights

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

Cornwall Park provides care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and supporting policies that are being implemented policy. Cultural assessments are undertaken on admission and during the review process. Policies are implemented to support resident rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Family members interviewed verified on-going involvement with 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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

across the facility meetings and to the organisation's management team. Four benchmarking groups across the organisation are established for rest home, hospital, dementia, psychogeriatric and mental health services. Cornwall Park is benchmarked in one of these (psychogeriatric). There are human resources policies including recruitment, selection, orientation and staff training and development. The service implements a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

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

Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. A registered nurse is responsible for each stage of service provision. Resident records reviewed provided evidence that the service has systems to assess, plan and evaluate care needs of the residents. Care plans reviewed overall identified service integration. Resident files include notes by the GP and allied health professionals. The activities programme is facilitated by an activities coordinator. Families report satisfaction with the activities programme. The programme is appropriate to resident cognitive and physical abilities. Medication management and practices reflects legislative requirements and guidelines. Education and medicines competencies are completed by all staff responsible for administration of medicines. All food is cooked on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are of sufficient size to promote safe mobility. External areas are secure. The facility hires a van for transportation of residents. There is one large dining room and one large lounge. There is a smaller quiet lounge and other sitting areas. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has adequate heating and temperature is comfortable and constant.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has six restraints (including one under environmental restraint) and no enablers in use. A register for each restraint is completed that includes a three-monthly evaluation. Review of restraint use across the group is discussed at regional restraint approval groups and at the facility in quarterly 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.		Some standards applicable to this service partially attained and of low risk.

The infection control programme is appropriate for the size and complexity of the service. There are appropriate policies and guidelines for the scope of the programme. The infection control officer is a registered nurse and is responsible for providing education and training for staff. The infection control officer has attended recent training and is supported by the organisations quality and risk team. Information obtained through surveillance is used to determine infection control activities such as education and internal audits within the facility.

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	6	6	0	0
Criteria	0	86	0	9	6	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	On admission families (and residents) are provided with information that includes a copy of the Health and Disability Commissioners Code of Health and Disability Services Consumers' Rights (the Code). Staff receive on-going training about the Code. Interview with four caregivers demonstrates an understanding of the Code and how they incorporate the various aspects into daily cares. Seven relatives interviewed confirm staff respect privacy, and support residents in making choice where able.
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	FA	The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code. Completed resuscitation treatment plan 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 four caregivers and one registered nurse (RN) confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both were filed.

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code and advocacy pamphlets on entry. Interviews with the relieving care home manager, the administrator confirm that practice is consistent with policy. Interviews with relatives confirm that they are aware of their right to access advocacy and that there are opportunities to be involved in decisions. The resident files include information on residents' family/whanau and chosen social networks.
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	The activities programmes includes links to the community. Interview with staff and family confirm that residents are supported as able to maintain their previous interests. Family confirm they can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints received are managed by the care home manager. The 2014 & 2015 complaints (YTD) were reviewed and there was a complaint management record completed for each complaint. All complaints had been investigated with appropriate documentation on record. A record of complaints each month is maintained by the facility on the complaint register. The number of complaints received each month is included in the Bupa benchmarking programme. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. A number of complaints were in regard to noise and the service continues to implement a number of corrective actions to minimise this. There was one HDC complaint which is currently in the process of being managed. Bupa is currently undertaking their own internal investigation into the complaint and as a result have an interim management team in place (link 1.2.8). Interview with relatives confirm they were provided with information on complaints and that a complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	The information pack provided to residents on entry includes how to make a complaint, the Code pamphlet, information about advocacy services and the Health and Disability Commission. The care home manager and registered nurses described discussing the information pack with residents/relatives on admission. The six monthly family forums also provide the opportunity to raise issues/concerns (minutes sighted). Relatives

Consumers are informed of their rights.		interviewed inform information has been provided around the Code. The families/EPOA are 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.
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	The service has a philosophy that promotes quality of life, involves relatives in decisions about their family-members care, respects their rights and maintains privacy and individuality. Individual preferences are identified during the admission and care planning process with family involvement. Seven resident files reviewed identified that individual preferences, including cultural and spiritual values, were identified on admission and then integrated into the resident's care plan. Instructions are provided to residents/relatives on entry regarding responsibilities around personal belongings in their admission agreement. Personal belongings were seen in resident rooms. The service encourages residents to have choice where able such as voluntary participation in daily activities. Interview with four caregivers described how choice is incorporated into resident cares. Interviews with family members were extremely positive about the care provided and the patience of staff. There is an abuse and neglect policy that continues to be implemented and staff attend in-service education on the topic. The relieving care home manager is the privacy officer. A tour of the facility confirms there is the ability to support personal privacy for residents. A family satisfaction survey was completed in June 2014 (80% return) that resulted in an 92% overall satisfaction with the service – including 100% of respondents indicating that staff considered privacy and 100% (excellent or good) around respectfulness.
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	Bupa has a Maori health plan and supporting policies that acknowledge the Treaty of Waitangi and provide recognition of Māori values and beliefs. Guiding documents were developed in consultation with Kaumatua and there are contact details of local iwi available. 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. There was one resident that identified as Maori. Interview with four caregivers could describe cultural appropriate practices.

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	Initial (and ongoing) care planning with the resident and/or whanau identify beliefs or values that are to be incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life'. Discussions with seven relatives inform values and beliefs are considered. There are a number of different cultures among residents and staff. A cultural day was held September 2014. Interviews with caregivers described how family let them know about different values and beliefs of the residents.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The code of conduct is included in the employee pack. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. There are appropriate policies to guide staff practice. Clinical meetings occur monthly (held with registered staff) and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirm an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Bupa has a robust quality and risk management framework that is being implemented at Cornwall Park. The framework ensures services adhere to the health & disability services standards. At an organisational level, there is a policy and procedure review committee to maintain 'best practice' guidelines/procedures. Bupa also has a Clinical Governance group. This group meets every three months and involves members of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. The Bupa geriatrician provides newsletters to general practitioners (GPs). Staff at facilities are encouraged to provide feedback on proposed changes to policy which are forwarded to the chair of the review committee. Technical experts are called upon as required. All facilities have a master copy of all policies and clinical forms. A number of clinical practices also have education packages for staff which are based on their policies. There is a human resources - learning and development fund policy. The objective of this policy is to ensure the on-going learning and development of all employees. The policy identifies funding available through Bupa for three staff categories a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants. There are required competencies for different staff types, and these are up to date at Cornwall Park. There is an annual education programme that is being implemented. ‘Tool box’ sessions, which are focused discussions with staff following for example a particular

		incident, are also seen to be provided regularly. Bupa has a strong focus on clinical benchmarking, both nationally and internationally. Nationally there are four benchmarking groups that compares clinical indicators across the different service levels. These are rest home, hospital, dementia, and psychogeriatric/mental health. Cornwall Park benchmarking is against the psychogeriatric levels. Trending data is provided to the service monthly and corrective actions are required to be completed when trends are above the prescribed benchmark. There were examples where the service had developed corrective actions (link 1.2.3.6). Staff interviewed confirmed they were kept informed of the incident trends via meetings and information kept in the staff room. Complaints are managed by the facility manager. Complaint numbers are overseen by the Bupa quality and risk team (link 1.1.13). Bupa has introduced a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). Of the 25 care staff, all have achieved bronze, and silver and 13 gold. Annual relative survey results indicate a high level of satisfaction with the service. Interview with seven relatives were positive about the care their family members receive.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure that guides staff in their responsibility to notify family of any accident/incident that occurs. Accident/incident forms include a section to indicate if family have been informed (or not) of an accident/incident. Thirty incident forms were reviewed from March 2015. Family had been notified appropriately in all instances. There is an interpreter policy and staff are aware of how to access interpreters if required. There are a number of residents (and staff) from a variety of cultures and caregivers described how they were able to communicate with residents where English is a second language. The seven relatives stated that they are informed when their family members health status changes Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. 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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are	FA	Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Cornwall Park has set specific quality goals for 2015 including (but not limited to); a) to enhance resident's & visitor's enjoyment of the hospital grounds by improving the external environment, b) Replace broken lazy boys with new furniture, repair any able to be repaired; c) minimise complaints about noisy

planned, coordinated, and appropriate to the needs of consumers.		residents; d) to further reduce the level of resident falls by 10%; e)To reduce weight loss by at least 10%. Cornwall Park provides specialist hospital level care (psychogeriatric) for up to 39 residents. Occupancy was 38 residents including one under hospital level care. There is an overall Bupa business plan and risk management plan. Bupa head office provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician also provides newsletters to GPs. The organisation has a Clinical Governance group. The committee meets three monthly. Specific issues identified in HDC reports (learning's from other provider complaints) are tabled at this forum. Two senior members of the Quality and Risk team are also members of the market unit, Australia/NZ clinical governance group Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. E.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators is also completed with another NZ provider. Facility Manager provides a documented weekly report to Bupa Operations Manager. The operations manager visits regularly and completes a report to the Director Care Homes/Rehabilitation. Cornwall Park is part of the Northern 2 Bupa region which includes eight facilities. The managers in the region teleconference weekly, Quarterly quality reports on progress towards meeting the quality goals identified are completed at Cornwall Park and forwarded to the Bupa Quality and Risk team. Meeting minutes reviewed included discussing on going progress to meeting their goals. ARHSS D17.5: The service is currently managed by an experienced relieving manager from another Bupa facility (specialising in psychogeriatric level care). The facility manager is supported by a relieving clinical manager (CM) from the Bupa Quality & Risk team. The relieving CM had previously been a CM at both Cornwall Park and Avondale care homes prior to working with the quality and risk team. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly (also link 1.1.13). ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.
Standard 1.2.2: Service Management The organisation ensures the day-to-day	FA	The relieving care home manager and clinical manager alternate on call responsibilities and there is a guideline available for staff to support decision making in respect of contacting management afterhours. The operations manager is also available to provide oversight and support.

operation of the service is managed 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	Bupa has a comprehensive quality and risk management system that is established at Cornwall Park. Quality goals are established and progress reported on quarterly. Goals have been evaluated. The quality programme includes monthly benchmarking by service type. Cornwall benchmarks against psychogeriatric level care. Benchmarking is also undertaken in respect of infection rates, antipsychotic usage and restraint usage. Benchmarking data is discussed at the quarterly quality meetings and then at the monthly staff meetings. Shortfalls around meeting minutes were noted. Cornwall has a health and safety committee that collates and discusses staff incidents /accidents. This data is also aggregated at an organisational level and reported monthly. The health and safety committee monitor objectives that are defined in the Bupa Health & Safety Plan. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. The service has a current hazard register, but not all hazards have been identified. Bupa policy review committee develop organisational policies appropriate for aged residential care services that align to current accepted practice. Policies are reviewed regularly and facilities are encouraged to have input into their review. Reviewed policies demonstrate feedback from relevant technical experts. There is a document control process being implemented that ensures the most current document is in use in clinical areas. Bupa prescribe an annual internal audit programme that is being implemented at Cornwall. Corrective action plans were developed and closed out in nine of 16 internal audits reviewed. There were examples where Cornwall Park had developed corrective action plans where monthly benchmarking outcomes rates were above the accepted threshold. However, these were inconsistently completed or not fully completed to reflect an evaluation. Staff are informed of audit outcomes and involved in corrective action plans.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are	PA Moderate	The service collects incident and accident data. The category one incidents policy (044) includes responsibilities for reporting category one incidents. The competed form is forwarded to the quality and risk team as soon as possible (within 24 hours of the event), even if an investigation is on-going. Thirty-three incident forms were reviewed across March 2015. Overall forms included follow up and clinical manager (or delegate) review and sign out. However shortfalls were identified around medication errors and updating care plans. The service documents and analyses incidents/accidents, unplanned or untoward events and examples were evident where feedback had

systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		been provided to staff (link 1.2.3.6). The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed and all had orientations and performance appraisals. Appropriate follow up in regards to a complaint about a staff member was not documented. 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 and includes documented competencies. New staff are buddied for a period of time. As part of their orientation caregivers complete a booklet that has been aligned with foundation skills unit standards, effectively attaining their first national certificates. There is an annual education schedule that is being implemented and an RN/EN training day provided through Bupa that covers clinical aspects of care. A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained. Staff interviewed were aware of the requirement to complete competency training. Bupa is the first aged care provider to have a NZ Nursing council approved PDRP. The nursing Council of NZ has approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. There is a staff member with a current first aid certificate on every shift. Current bureau registered nurses have completed an induction specific to bureau staff. There are 21 caregivers, 15 have completed the required dementia standards and six are currently in the process.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or	FA	There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above. There is at least one RN (currently call bureau staff except for one RN) and first aid trained member of staff on every shift. There is a qualified diversional therapist at the facility. Interviews with staff and relatives inform there are sufficient staff to meet the care needs of the residents.

experienced service providers.		
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Care plans and notes are legible and where necessary signed (and dated) by a registered nurse. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration and are legible, dated and signed. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.
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	The service has comprehensive admission and assessment policy and processes and resident's needs are assessed prior to entry. Information gathered at admission is retained in resident's records. Seven family interviewed stated they were well informed upon admission. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights. The service conducts an assessment of needs on entry of a resident to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow up. There is a transfer plan policy. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. The service has been trialling the Medichart online medication delivery system. This however has not yet gone "live", therefore the RNs have been using the Medichart system to view medication charts but are signing for the administration of medications on medication signing sheets. All registered nurses who administer medications have been assessed for competency on an annual basis. Seniors caregivers have been assessed for competency

and timely manner that complies with current legislative requirements and safe practice guidelines.		for checking controlled drugs only. Education around safe medication administration has been provided. The registered nurse interviewed was able to describe their role in regard to medicine administration and was observed safely and correctly administrating medications. A contracted pharmacy supplies packed medications. Medications are managed appropriately in line with required guidelines and legislation. Each drug chart has a photo identification of the resident. Allergies or nil known allergies were recorded on the medication chart. Internal medication audits are conducted six monthly. Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly. Four of fourteen medication charts reviewed did not record indication for use of as required medication by the GP. The service monitors and evaluates residents on antipsychotic medication monthly as evident in three medication charts sampled. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed
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	All meals at Bupa Cornwall are prepared and cooked on site. There is a six weekly summer and winter menu with dietitian review and audit of menus. Meals are prepared in a kitchen adjacent to the main dining room for serving. Cooks and kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. A dietitian is available via referral to review residents. Supplements and fortified foods are provided to residents with identified weight loss issues. The cook was fully aware of all resident with weight loss issues and all residents' food preferences. Weights are monitored monthly or more frequently if required and as directed by the dietitian (# link 1.3.6.1). Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service. There is evidence that there are additional nutritious snacks available over 24 hours. Caregivers were observed assisting resident with meals during the audit.
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	FA	There is an admission information policy. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Bupa Cornwall completes the Bupa assessment booklets and care plan templates for all residents. Risk assessment tools and monitoring forms are reviewed at least six monthly for six of seven long term resident files reviewed (link #1.3.3.3). Assessments have been used to effectively assess level of risk and required support for residents. Personal needs information is gathered during admission and needs, outcomes and goals of consumers are identified. An initial support plan has been completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse. All seven files sampled contain assessments and support plans which are comprehensive and include input from allied health. The assessment booklet includes input from team members. Notes by GP and allied health professionals are evident in resident's files, significant events, communication with families and notes as required by registered nurses. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	An initial care plan had been developed within 24 hours in the sample of files reviewed (# link 1.3.3.3). Service delivery plans (care plans) were overall comprehensive and demonstrate service integration and input from allied health. Overall residents' care plans reviewed on the day of the audit provide evidence of individualised support (link 1.3.6.1). Residents and family members interviewed confirmed that care delivery and support by staff is consistent with their expectations. Short term care plans are in use for changes in health status and files reviewed identified that family were involved (# link 1.3.8.2).
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	A written record of each resident's progress is documented. Appropriate services to meet resident's needs were evidence in four of seven files reviewed. Changes are followed up a registered nurse (# link 1.3.3.4). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate professional is actioned. The clinical staff interviewed (one newly employed and one bureau) advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and a treatment room is well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds. Four residents had pressure areas (grade 1 and grade 2) with evidence of wound specialist input. Wounds were being reviewed by the relieving clinical manager overseeing the service currently. Advised that wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN were evidenced. A physiotherapist is

		employed by the service for four hours per week for resident assessment. A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by an R.N. During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.
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.	FA	The activities coordinator at Bupa Cornwall provides an activities programme over five days per week. Group activities are voluntary. Residents are able to participate in a range of activities that are appropriate to their capabilities. Bupa Cornwall hires a van and driver which is used for resident outings at least twice a week. The activities coordinator accompanies the resident on outings. The group activity plans are displayed on notice boards around the facility. Residents who do not participate regularly in the group activities are visited for one on one sessions, with records kept to ensure all such residents are included. All interactions observed on the day of the audit indicated a friendly relationship between residents and the activity coordinator. Each resident has a map of life developed on admission which forms the basis of the activities plan. The resident files reviewed included a section of the long term care plan for activities, which has been reviewed six monthly. The care plan includes activity over a 24 hour period. The activities coordinator has maintained six monthly reviews. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys. A comprehensive social history is complete on or soon after admission and information gathered is included in the long term care plan. The activity care plan is developed with the relative/whanau and this is reviewed at least six monthly. Caregivers were observed various times through the day diverting residents from behaviours. Caregivers assist with activities over the weekend and evenings and there is always a caregiver present in the lounge to observe and monitor residents. The programme observed was appropriate for older people with mental health conditions.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Initial care plans are evaluated within three weeks of admission (# link 1.3.3.3). Long term care plans are reviewed and evaluated by the registered nurse at least six monthly for three of six files reviewed (# link 1.3.3.3) or when changes to care occur. A multi-disciplinary team meeting is conducted six monthly for each resident and involves all relevant personnel. The GP's examine the residents and review the medications three monthly. Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long term care plan as an on-going problem. Not all acute changes in health status have been documented.
Standard 1.3.9: Referral To Other	FA	Of the sample group of notes all of the residents EPOA had signed the informed consent and had copies of the Code of Rights. Referral to other health and disability services was evident in sample group of resident files. The

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.		service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided an example of where a resident's condition had changed and the resident was reassessed for a different level of care due to behaviours diminishing.
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.	PA Low	Chemical/substance safety policy guides all staff in the management of all waste and hazardous substances. Management of waste, chemical safety and hazardous substances is covered during orientation of new staff and subsequent training sessions have been held around chemical safety. Chemicals are clearly labelled with manufacturer's labels however one chemical on the cleaner's trolley being used was not labelled. Sharps containers are available and meet the hazardous substances regulations for containers. Hazard register identifies hazardous substance and staff indicated on interview a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and are evident in all areas of the facility. Infection control policies state specific tasks and duties for which protective equipment is to be worn.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	There is a maintenance person who has been at the service for one week and works casually and is on call for the Bupa group. Reactive and preventative maintenance occurs, however there is no record of preventative maintenance for three months of 2015. Fire equipment is checked by an external provider. The service displays a current building warrant of fitness which expires on 19 October 2015. All medical equipment has been calibrated and checked. Hot water temperatures are checked in each of the wings and records sighted evidence that temperatures are maintained at no more than 45 degrees Celsius. All floor areas are vinyl surfaces. The corridors have hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are maintained with gardens and outdoor seating and shade available. The outdoor area is secure with walking paths. There is wheelchair access to all areas. Two of the doors to the outdoor area have a coded key pad access. One sliding door provides outdoor access with no coded key pad. There is a quiet, low stimulus area that provides privacy when required however this quiet area has a lock on the door which limits residents

		exiting (link 2.2.4).
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 the residents' rooms at Bupa Cornwall care home are either single or shared rooms with hand basin facilities. There are sufficient toilets and communal showers for the resident population. There are also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and privacy locks. Paper hand towel dispensers and flowing soap are available for use in all toilet areas. Relatives interviewed reported that their love ones privacy is maintained at all times.
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	The resident rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Staff report that rooms have sufficient room to allow cares to take place. Staff were observed on the days of audit using equipment in resident's rooms and throughout the facility.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and	FA	There is one large dining room and a large lounge, as well as smaller seating areas in the corridor. The lounge and dining rooms are accessible and can accommodate the equipment required for the residents. Activities occur in the lounge or one on one in resident's room. There is a family lounge area. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were observed on the days of audit freely moving around the facility and staff assisting them if required.

accessible areas to meet their relaxation, activity, and dining needs.		
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.	PA Moderate	There are policies for cleaning and laundry processes. All laundry is completed by an external contractor. There are daily deliveries of laundry. There are dedicated cleaning staff. The cleaning staff manage the collecting of dirty laundry and delivery of clean laundry. Areas of the facility required attention to cleaning on the days of audit. Laundry and cleaning audits have been conducted. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. There is a sluice room for the disposal of soiled water or waste. This was locked when unattended.
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. Staff training in fire safety and fire drills has occurred. Fire drills are held six monthly – last conducted in March 2015. Emergency management training is held as part of staff orientation with annual competencies completed. There is a comprehensive civil defence manual and emergency procedures manual in place. A civil defence kit is readily accessible as well as a daily updated resident register. There is an approved evacuation plan. The facility is prepared for civil emergencies with provision and storage of emergency supplies. The call bell system in place includes an indicator panel in each wing and there are surveillance cameras in the corridors. During the tour of the facility, staff and relatives were observed to have easy access to the call bells. Security checks are conducted by evening staff and a contracted firm.
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	FA	The facility has appropriate heating which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored monthly. Relatives interviewed stated the temperature of the facility was comfortable and this was observed on the days of audit. There is sufficient natural light in resident's rooms.

and comfortable temperature.		
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 determined by the organisation and is reviewed annually. The programme is appropriate for the size and complexity of the service. Infection control is currently being overseen by the relieving clinical manager at Cornwall Park. There is a job description outlining responsibilities for the role. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases (link 3.5.7).
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	At Cornwall Park, the infection control committee is made up of a cross section of staff. The committee meet quarterly to discuss infection rates, education and internal audit outcomes. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.
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	FA	The infection control manual includes comprehensive policies and guidelines that comply with accepted good practice. Guiding policies are available for all service area including the kitchen, laundry and housekeeping services. External expertise can be accessed as required, to assist in the development of policies.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control officer is responsible for coordinating and delivering training to staff. This includes the training delivered as part of the orientation programme for new staff. The relieving clinical manager (IC coordinator) has completed external training around infection control. The IC meeting minutes (September 2014) included training for staff on ESBL. Other training around norovirus Oct 2014, and Infection control/MRO in November 2014 has been provided. Toolbox talks have been provided at handovers around current issues in 2014 and 2015 (YTD). These have included (but not limited to) hygiene needs, eye hygiene, food safety audit results, ESBL/MRO, and cleaning.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low	There is a surveillance programme that is suitable to the size and complexity of the service. The infection control officer coordinates the surveillance programme including collation and aggregation of monthly infection rates. Corrective action plans are seen to have been developed and implemented when infection rates exceed the expected targets. The surveillance of infection data assists in evaluating compliance with infection control practices. A gastro outbreak was identified December 2014. There were no records/meeting minutes to identify how the gastro outbreak was managed. 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. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the

		service.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a regional restraint group at an organisation level that reviews restraint practices and also monthly restraint meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). 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 a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has six restraints (including one under environmental restraint) and no enablers in use. A register for each restraint is completed that includes a three-monthly evaluation. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level.
Standard 2.2.1: Restraint approval and processes 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.	FA	All staff restraint competency assessments have been completed. Interview with the restraint coordinator (relieving clinical manager) identifies understanding of the role. The restraint coordinator role ensures education is provided and competency assessment for staff is up to date. All staff in the facility have to pass restraint competency annually. Restraint is used for the minimum time and this is evidenced on monitoring forms. Staff could describe the process of trying to minimise the use of restraint. Lap belts are monitored hourly and bedrails two hourly.
Standard 2.2.2: Assessment Services shall ensure	FA	Assessments are undertaken by the registered nurses in partnership with the family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved

rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		restraint for safety. Ongoing consultation with the family/whanau is also identified. Falls risk assessments have been completed at least six monthly. Challenging behaviour assessment/management plans have been completed as required. Assessments reviewed were completed as required and to the level of detail required for the individual residents. Restraint files were reviewed. The file included a completed assessment that considered those items listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy (bed rails, lap belts and environmental restraint). The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. One resident (reassessed as hospital level) has been assessed as being on environmental restraint. Interventions are clearly documented. The service has a quiet lounge with stable doors. The lower door can be locked. This lounge is off the main lounge and the lower stable door is mainly kept locked during the day. Later in the afternoon immobile residents that require a quieter space are kept in this lounge so as not to be disturbed by wandering and agitated residents. During this time the lower stable door is locked. Staff were observed checking residents in the quiet lounge regularly and they could describe how checks at least every 15mins were completed. One caregiver is assigned to oversee both lounges at all times. Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed 2-3 monthly during the facility restraint meetings and also as part of the three-monthly restraint reviews and six monthly multi-disciplinary meetings and include family/whanau input. restraint incidents/adverse events that have occurred are not evident as having been discussed at the restraint meeting (link 1.2.3.6). Monitoring is documented and the use of restraint evaluated. The resident file refers to specific interventions or strategies to try (as appropriate) before use of restraint. The two care plans reviewed of residents with restraint did not identify potential risks/ observations and monitoring requirements (link 1.3.6.1). A restraint register is in place providing an auditable record of restraint use.
Standard 2.2.4:	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the on-going reassessment for the resident on the restraint register, and as part of the care plan review. Five

Evaluation Services evaluate all episodes of restraint.		evaluations reviewed identified families were included as part of this review. Restraint is also evaluated on a formal basis 2-3 monthly at the facility restraint meeting and six monthly by the regional restraint team.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage throughout the Bupa organisation is monitored regularly. The review of restraint use across the Bupa facilities is discussed at the regional restraint approval group meetings. The restraint committee at Cornwall Park includes individual review of residents with restraint (link 1.2.3.6). The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. Monitoring of lap belts is undertaken hourly and bed rails two hourly. Monitoring forms were reviewed for two residents and these were completed.

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The service collects quality data, completes an analysis and implements corrective actions. In 2014, their quality goals was to reduce falls by 10%. Corrective actions were established. Quarterly evaluations included varying results with on-going corrective actions. Falls reduced 6% in March, 20% in July, and increased in August with the admission of a new resident. From Sept to Dec2014 falls had reduced. Falls continue to be a focus in 2015. The 2014 goals also included a goal around reducing	(i)While meeting minutes identify discussions of quality data collected, there is a lack of documented evidence that issues are followed through, actioned and evaluated. (ii) While quality goals are well documented and progress reported through meetings, documentation of other clinical indicator analysis is limited. (iii) Where QI – corrective actions have been established following benchmarking outcomes there is little documented evidence that these have been implemented. (iv) Two restraint incidents reviewed had not been discussed at restraint meetings to identify actions to mitigate risk. (v) Internal audit corrective action plans developed had not been closed out in nine of 16 internal audits reviewed.	(i) Ensure the meeting minutes identify follow up of actions required. (ii) Ensure documentation reflects discussion of clinical indicators; (iii) Ensure corrective actions are established and evaluated as a result of benchmarking results; (iv) Ensure restraint incidents are discussed at restraint meetings. (v) Ensure corrective actions established from shortfalls identified from internal audits evidence

		bruising by 10%. While actions were established and were noted to have decreased in 2014, bruises remained above the benchmark Jan2014 – July 2014. The service has a number of meetings including monthly registered nurse meetings. While meeting minutes identify discussions of quality data collected, there is lack of documented evidence that issues were followed through and evaluated. While quality goals are well documented and regularly evaluated through meetings, other clinical indicator analysis is limited. Where QI – corrective actions have been established following benchmarking outcomes there is a little documented evidence that these have been implemented.		implementation. 180 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly	PA Low	Cornwall has a health and safety committee that collates and discusses staff incidents /accidents. This data is also aggregated at an organisational level and reported monthly. The health and safety committee	The current hazard register has not been updated to include the identified risks around the outdoor garden, and potential for T-belts to break	Ensure the hazard register identifies all current hazards 60 days

associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		monitor objectives that are defined in the Bupa Health & Safety Plan. The hazard register at Cornwall park is not up to date.		
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Thirty-three incident forms were reviewed across March 2015. Overall forms included follow up and clinical manager (or delegate) review and sign out. However shortfalls were identified around medication errors and updating care plans.	(i)Follow up/sign off of incidents are documented by the managers on the incident forms. Six incident forms reviewed with corrective actions identified were not updated in resident care plans; (ii) five medication incidents March 2015, lacked detail around follow up.	Ensure care plans are updated as a result corrective actions identified on incident forms. (ii) Ensure incident forms are fully completed 60 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	There are policies including recruitment, selection, orientation and staff training and development.	A complaint lodged about one staff member did not include any follow up letter/interview to determine whether disciplinary action should be taken.	Ensure staff performance/complaints are followed up 90 days
Criterion 1.3.12.6 Medicine management information is recorded to a	PA Moderate	Ten of fourteen medication charts reviewed had documented reason for use	(i) Four of fourteen medication charts reviewed did not record indication for use of as required medication by the GP so as to safely guide	(i) Ensure that reason for use of as required medication is

level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.		of as required medications by the GP to safely guide staff. Registered nurses administered medications. Bupa monitors and evaluates residents on antipsychotic medication monthly as this is evident at Cornwall Park in three medication charts sampled.	staff. (ii) Three residents prescribed antipsychotic medication did not have evidence of monthly review/evaluation of antipsychotic medication used as per Bupa policy.	documented on the residents medication chart by the GP. (ii) Ensure that all resident prescribed antipsychotic medication has a monthly review/evaluation documented. 60 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 Moderate	Seven resident files were sampled. Six of seven files identified that assessments and initial care plans were completed within 24 hours. Five of seven files sampled identify that the long term care plan was completed within three weeks. There is documented evidence the care plans were developed and reviewed by a registered nurse. Six of seven long term care plans have been reviewed within six months and have been amended when current health changes. A six monthly case conference multidisciplinary (MDT) care plan review involving the RN, activities staff, caregiver, and family members has been conducted. Spirituality, cultural and social needs are	(i)One of seven files did not have a nursing assessment completed on admission. (ii)Two files sampled did not evidence that the long term care plan was developed within three weeks following admission. One care plan was developed seven weeks after admission and one care plan was developed six weeks following admission. (iii) One residents care plan and risk assessments had not been evaluated six monthly (developed 1 October 2014)..	Ensure that all aspects of care planning including nursing assessment reviews and care plan evaluations are conducted within the contracted time frames. 60 days

		included in the initial assessment and long term care plan.		
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Moderate	Progress notes are maintained daily and more often if required following resident incidents or health changes to ensure continuity of service delivery.	One resident had a fall in April 2015 sustaining skin tears with documentation in the progress notes by the registered nurse and an incident form completed. There was no comprehensive documented follow up of the falls incident and resident assessment. There was only one entry in the progress notes the following day from the registered nurse stating that the resident seemed sleepy, had meals and went to bed. The following day there was documentation from the registered nurse stating that the resident was up and around nil new concerns. The resident was admitted to hospital the next day with limited arm movement and complaining of pain. Advised the resident was only sent to hospital to rule out if the complaints of pain were as a result of a fracture and no fracture was diagnosed.	Ensure that there is a documented comprehensive follow up and assessment by the registered nurse of residents following incidents. 60 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	Four of seven files reviewed evidenced appropriate interventions in care plans to meet resident's needs. Seven resident files included individualised behaviour management. Education on challenging behaviour has been completed. There is specialist input into residents in the unit. A psycho-geriatrician visits	Three resident files sampled did not evidence that services and /or interventions were meeting the resident's needs. (i) One resident's has ESBL and the care plan interventions state "measures in place" but no detail of what the measures were. (ii) One other resident had noted weight gain, (care plan comments that the resident is prone to weight gain) however the care plan has not been updated with documentation on the weight gain. The same resident requires blood sugars to be taken twice weekly as detailed in the care plan.	(i) Ensure that all care plans reflect interventions to support assessed needs. (ii) & (iii) Ensure monitoring charts are completed as required and this is reviewed by clinical staff; (iv) Ensure care plans identify interventions to manage risks related to restraint.

		frequently and is readily available to staff. The GP visits twice per week and more frequently if required. Strategies for the provisions of a low stimulus environment could be described in interviews with staff	There were no documented blood sugar recordings for April 2015. (iii) One other resident has no evidence of behaviour monitoring despite aggressive behaviours. The same resident has been seen by the psycho-geriatrician in May 2015 who documents to keep the resident separated from others. There was no follow up of this comment. No plan has been implemented to detract resident from others. The relief clinical manager advised she would be contacting the specialist to follow up this instruction. (iv) Two care plans reviewed of residents with restraints, did not have documented interventions to manage identified risks or monitoring requirements.	60 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long term care plan as an on-going problem. Short term care plans included but not limited to; dental care for broken teeth, toileting, depression and care of a fracture.	Two residents with weight loss do not have a short term care plan (STCP) developed or the long term care plan (LTCP) updated. One of these residents had lost eight kilograms following an acute hospital admission. There is evidence that the resident weight has increased recently. A short term care plan was developed on the day of audit. Another resident admitted in February 2015 had noted weight loss of three kilograms in April 2015. The residents long term care plan states for the clinical nurse manage to follow up if there is over one kilogram weight loss in a month. The resident's weight in May 2015 had a slight increase.	Ensure that all residents have acute changes in health status either documented on a STCP or updated in the LTCP 90 days
Criterion 1.4.1.1 Service providers follow a documented process for the	PA Low	Chemicals are supplied by an external company. Chemicals are labelled with	On the day of audit the cleaner had an unlabelled chemical for use on the cleaning trolley.	Ensure that all chemical have manufactures labels for clear

safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.		manufacturers labels, stored safely and safety data sheets are available.		identification of the chemical and to maintain safe chemical use. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a Bupa annual preventative maintenance schedule including monthly hot water temperature checks. There are hand basins in the resident rooms for individual use and maintain infection control.	There is no documented evidence of preventative maintenance checks completed for January, February and March 2015. Seven formica tops/surrounds of the hand basins in resident rooms were found to be cracked. There is evidence of new hand basins in some resident's rooms that replaced those that are cracked.	Ensure that all preventative maintenance and hot water temperature checks are completed as per the Bupa schedules to maintain a safe and appropriate environment. Ensure that all equipment is safe for resident use. 180 days
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	There are three exit doors to safe and secure external garden areas	Two of the exit doors have key coded pads and are kept locked. The service has a rational for the locked doors due to the service deeming the outdoor garden area to be unsafe with uneven surfaces. There is also the potential to abscond or for residents to be in danger from climbing the garden bank. The service has identified as one of the goals to improve the garden providing safety and interest for the residents (link 1.2.1). Advised that staff assist residents to access this area when weather permits and relatives can take residents out at any time.	Ensure that there is easy access to a safe and secure external garden area so that residents can freely access at any time. 180 days

Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Moderate	There are dedicated staff for cleaning services. There is one cleaner rostered daily.	The shower/bed trolley for use by all residents was unclean (faeces smeared) on the first day of audit and remained unclean on the second day of audit. One of the resident's communal toilets was found to be in an unreasonable state on the morning of the audit and was unattended up until the end of the audit day.	Ensure that all equipment and areas are kept hygienically clean for all residents use. 30 days
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	Corrective action plans are seen to have been developed and implemented when infection rates exceed the expected targets. In December 2014 an outbreak of diarrhoea and vomiting affecting 10 residents was managed. A case log was documented and advised the outbreak was reported as required. However, there was no records/meeting minutes to identify how the outbreak was managed and the quality meeting stated "no IC trends'. An incident form was sighted as completed for the outbreak.	There was no records/meeting minutes to identify how the gastro outbreak was managed December 2014 and the quality meeting stated "no IC trends'	Ensure processes are clearly documented and evaluated around management of outbreaks. 180 days
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its	PA Low	The service has a quiet lounge with stable doors. The lower door can be locked. This lounge is off the main lounge and the lower stable door is mainly kept locked during the day.	(i) There is no documented procedure to mitigate risk around the management of locking immobile residents in the room. (ii) There has been one incident identified where a mobile resident had managed in get into the lounge and was unable to get out until staff undid the	(i) Ensure there are procedures in place to ensure a locked door is managed appropriately (ii) Ensure the locked door is included as part of risk/hazard

outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.		Later in the afternoon immobile residents that require a quieter space are kept in this lounge so as not to be disturbed by wandering and agitated residents. During this time the lower stable door is locked and the other open so residents can be sighted easily. Staff were observed checking residents in the quiet lounge regularly and they could describe how checks at least every 15mins were completed. One caregiver is assigned to oversee both lounges at all times and therefore the risk has been identified as low.	bolt.	management and processes are implemented to mitigate the risks 60 days

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.