

Bupa Care Services NZ Limited - Cashmere View Rest Home & Hospital

Introduction

This report records the results of a Partial Provisional Audit; 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: Cashmere View Rest Home and Hospital

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

Dates of audit: Start date: 24 August 2015 End date: 25 August 2015

Proposed changes to current services (if any): Reconfiguring 29 rest home beds to 29 dual-purpose beds; increasing psychogeriatric beds from 20 to 44 by converting a hospital unit in to a 24 bed psychogeriatric unit.

Total beds occupied across all premises included in the audit on the first day of the audit: 89

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
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

Cashmere View is part of the Bupa group. The service is certified to provide hospital (medical, geriatric and psychogeriatric), and rest home care for up to 103 residents.

The care home manager at Cashmere View is experienced in aged care and management. The clinical manager is also experienced in aged care. 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.

A 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.

A partial provisional audit was also conducted against the health and disability service standards and the contract with the DHB, in relation to the conversion of a hospital wing into a 24 bed psychogeriatric unit and the reconfiguration of the 29 bed rest home wing into 29 dual purpose beds. The audit process included a tour of the proposed unit, interviews with management and review of policies and procedures.

The 29 bed rest home and hospital wing has been assessed as appropriate for the provision of rest home and hospital level care (dual purpose).

The conversion of the 24 bed hospital unit in to a 24 bed psychogeriatric unit is yet to be fully completed.

The service is commended for achieving continued improvement ratings around quality clinical indicators and good practice.

The certification audit identified that improvements are required around ensuring all complaints are managed, ensuring that all care staff in the psychogeriatric unit have completed the required unit standards, and implementing corrective actions when hot water temperatures are not within acceptable limits.

The partial provisional audit identified that improvements are required prior to occupancy of the 24 bed psychogeriatric unit. These include ensuring the unit and external garden areas are secure, completing the refurbishment to include a dining and lounge area, providing an update on the fire evacuation scheme and providing a secure medication storage system.

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.
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Bupa Cashmere endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Māori 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. 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 available. Residents and family interviewed verified ongoing 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 low risk.
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Cashmere View 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 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. Cashmere View is benchmarked in three of four of the Bupa benchmarking groups (hospital, rest home and psychogeriatric). There are human resources policies to guide practice and an orientation programme that provides new staff with relevant information for safe work practice. The in-service training programme covers relevant aspects of care. External training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Partial Provisional: The care home manager and clinical manager are appropriately skilled and qualified to manage the service. Current staff including; registered nurses and caregivers are available to staff the new unit. A proposed roster is available.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Certification: 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 three monthly general practitioner review. 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 on admission and all meals cooked on site. This includes consideration of any particular dietary preferences or needs.

Partial Provisional: The current medication system in use will be utilised in the new psychogeriatric unit. The kitchen is equipped to cater to the residents needs in the psychogeriatric unit.

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 low risk.
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Certification: The building has a current warrant of fitness. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. There is sufficient space to allow the movement of residents around the facility using mobility aids. The hallways and communal areas are spacious and accessible. There is wheelchair access to all areas. The outdoor areas are safe and easily accessible. The service has an approved fire evacuation scheme. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Housekeeping staff maintain a clean and tidy environment. All laundry and linen was completed on-site. External areas are safe and well maintained. 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.

Partial Provisional: There is a locked storage area available for secure chemical storage. The facility has a current building warrant of fitness. Furniture and equipment is available and appropriate to the level of care required. Cleaning and laundry systems are in place. All rooms are single rooms – 12 have full ensuite facilities, and 12 have access to shared communal facilities.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has four hospital residents and two psychogeriatric residents with restraint and three hospital residents with enablers. Restraint includes bedrails and lap belts. 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

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

Partial Provisional: The infection control programme team is responsible for infection prevention and control and the programme is led by a registered nurse with support from the organisation.

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	2	42	0	6	0	0	0
Criteria	3	90	0	8	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Bupa has policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights. Six family members (one rest home, two hospital and three psychogeriatric) and 10 residents (five rest home and five hospital), advised that they were provided with information on admission, which included the Code of Rights. Staff receive training around resident rights at orientation and as part of the annual in-service calendar. Resident rights/advocacy staff training occurred in March 2015. Interviews with six caregivers (three rest home and three hospital/psychogeriatric) and seven nurses (five registered nurses and two enrolled nurses) demonstrated an understanding of the Code of Rights principles.</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 consent.</p>	FA	<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. There is evidence of general practitioner (GP) and family discussion regarding a clinically 'not indicated' resuscitation status. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering</p>

		rooms and so on. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed with the admission agreements. Where legal processes are ongoing to gain EPOA this is recorded, as are letters of request to families for the supporting documentation.
<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	<p>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/whānau and chosen social networks.</p>
<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	<p>Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations. Visitors were observed coming and going at all times of the day during the audit. The activities policy encourages links with the community. This was seen to be implemented at Cashmere View with the activities programmes including opportunities to attend events outside of the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>There is a complaints procedure to guide practice. The care home manager has the overall responsibility for managing the complaints process at Cashmere View. A complaint management record has been completed for each complaint, except for one complaint that has not been responded to within the service policy timeframes. 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 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</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The information pack provided to resident's on entry includes the Code of Rights information on how to make a complaint. On entry to the service, the care manager or the clinical manager will discuss the information pack with the resident and their family/whānau. Advocacy brochures are displayed in the reception. Advocacy is brought to the attention of residents and families on admission and via resident meetings, relative/family meetings and the information pack. Interviews with residents and relatives identified they were aware of their rights and could approach the managers at any time if they have concerns.</p>
<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>	<p>FA</p>	<p>During the audit, staff demonstrated gaining permission prior to entering resident private areas. Resident files were stored securely. All care staff interviewed demonstrated an understanding of privacy. Residents and family members interviewed, confirm that staff promote resident independence wherever possible and that resident choice is encouraged. Residents' values and beliefs information are gathered on admission with family involvement and is integrated with the residents' care plans. Care plans reviewed identified specific individual likes and dislikes. This includes cultural, religious, social and ethnic needs. Interviews with six caregivers (across the service) identified how they get to know resident values, beliefs and cultural differences. There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training. Abuse and neglect staff training has been provided.</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>	<p>FA</p>	<p>Bupa has a Māori 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. On the day of the audit there were no residents who identified as Māori. Family/whānau involvement is encouraged in assessment and care planning. Visiting is encouraged. Cultural needs are addressed in the care plan. Staff receive cultural awareness training. Links are established with disability and other community representative groups as requested by the resident/family.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate, their family/whānau. Values and beliefs have been discussed at the initial</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>care planning meeting and then incorporated into the care plan. Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs. Staff recognise and respond to values, beliefs and cultural differences.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Staff were aware of the actions they should take in the event that they believe a staff member is not maintaining a professional approach to practice.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	CI	<p>Services are provided at Cashmere View 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 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 through Bupa, of which Cashmere View is benchmarked against hospital, rest home 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. The standardised annual education programme, core competency assessments and orientation programmes, were all seen to be being implemented at Cashmere View. The "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s), is being implemented. Staff progress is reported at the staff meetings. Discussions with residents and relatives were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff of 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</p>

		<p>available. 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. The care manager and clinical manager have an open door policy. Information specific to the psychogeriatric 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>FA</p>	<p>Cashmere View is a Bupa facility, which provides rest home, hospital - including medical and psychogeriatric, level care for up to 103 residents. Occupancy on the day of audit was 89 residents. The Palmside psychogeriatric unit had 20 residents; there were 27 rest home residents including two respite residents; there were 42 hospital residents including two respite residents. Two of the hospital residents reside in the Ashgrove wing which is a 29 bed unit approved for dual purpose beds. There were no residents under the medical contract.</p> <p>The philosophy of the service includes providing safe and therapeutic care for residents requiring rest home, specialised dementia care and hospital care. Bupa have identified six key values that are displayed at Cashmere View. 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. The plan for 2015 for Cashmere View includes a focus on reducing pressure injuries by 20%, reducing falls rate by 10%, reducing the incidence of bruising by 20%, and reducing the rates of urinary tract infections. Progress towards goals has been reported through the various meetings, for example the quality meeting, full staff and clinical meeting. Cashmere View participates in the organisations benchmarking programme that monitors key aspects of care.</p> <p>The care home manager at Cashmere View is an experienced manager (non-clinical) and has an aged residential care background. She has been in the role for six months. The care home manager is supported by a clinical manager (registered nurse) who oversees clinical care and has been in the role for one month. Her previous role was unit coordinator at Cashmere View. The management team is supported by the wider Bupa management team, which includes an operations manager (interviewed). 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</p>

		<p>manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a hospital.</p> <p>Partial Provisional: The service has a business plan for the refurbishment of the 24 bed unit and the change in service level from hospital to psychogeriatric. Twelve resident rooms are still in use for hospital level residents. A further 12 bedrooms have been designated as the initial part of the psychogeriatric unit and include a lounge and dining area, a nurses station, a treatment room and a secure external garden area. Work is currently being completed on this project (link #1.3.12.1, 1.4.2.4, 1.4.2.6, 1.4.5.1, 1.4.7.3). The business plan (project) includes processes for the management of existing residents, staffing, proposed rosters, refurbishment work, health and safety and infection control. The refurbishment work is project managed by a contractor.</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>Certification and Partial Provisional: 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>	CI	<p>Cashmere View is implementing 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. Policy review is coordinated by Bupa head office. The service has comprehensive policies/procedures to support service delivery including InterRAI policy. The quality programme includes an annual internal audit schedule, which is being implemented at Cashmere View. 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</p>

		<p>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>There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Cashmere View is proactive in developing and implementing quality initiatives.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Death/Tangihanga policy and procedure outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. 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>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Cashmere View collects incident and accident data on the prescribed form. The sample of 11 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.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>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 is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The sample of staff files reviewed included one clinical manager, one activities</p>

		<p>assistant, four caregivers, one enrolled nurse and three registered nurses. All staff files were reviewed and included all appropriate documentation. Staffing levels are stable with some staff having been employed for more than 20 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Care staff complete a level two Foundation standard qualification as part of their orientation. 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 is a completed in-service calendar for 2014 and a plan for 2015, which is being implemented. These programmes have exceeded eight hours of annual training for staff. Caregivers have completed either the national certificate in care of the elderly or have completed or commenced the career force aged care education programme. The manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local DHB. Care staff including activities assistants complete dementia specific unit standards with the exception of two staff who work in the existing 20 bed psychogeriatric unit.</p> <p>Partial Provisional: Existing human resource processes will be implemented in the staffing of the 24 bed psychogeriatric unit. Staff who worked in the unit when it was hospital level care has been retained and are currently working throughout the facility. Staffing levels will be increased according to resident numbers and acuity.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements. The Wage Analysis Schedule (WAS) 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 a minimum of two registered nurses plus care staff on every shift. Interviews with caregivers advise the nursing staff and management are supportive and approachable. Staff interviewed advised that there is sufficient staff on duty at all times.</p> <p>Partial Provisional: A proposed roster has been developed for the 24 bed psychogeriatric unit (Barrington). It is the intention of the service initially, to open half the unit. The first 12 beds will be within a locked secure unit (#link 1.4.2.4). The remaining 12 beds will continue as</p>

		hospital level care until the full 24 bed psychogeriatric unit is required. Staffing will initially be one registered nurse and one caregiver on each shift and will increase as residents increase to 12. The Barrington unit is located adjacent to the existing 20 bed psychogeriatric unit (Palmside). The intention is for activities staff to work between the two units.
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 reviewed 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.
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	There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry, including admission to psychogeriatric unit. An advocate is available and offered to family. The admission agreement reviewed aligns with the service's contracts. Ten admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that 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 communication with family is made.
<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>	PA Low	<p>Certification audit: There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were nine residents assessed in the rest home as competent to self-administer medication on the day of audit. There is a medication room for each unit. All medications were securely and appropriately stored. Registered nurses or senior caregivers, who have passed their competency, administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and 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 20 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 medication charts reviewed have as needed medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges. Medication administration charts were signed as medication was administered.</p> <p>Partial Provisional: The service intends to use a locked treatment room for the safe storage of medications. On the day of the audit, the treatment room was not completed for safe storage of medication.</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>	FA	<p>Certification audit: The service employs one cook and one relieving cook; both have completed food safety certificates. On the day of the audit, the cook had been in the position for a week. The procurement of the food and management of the kitchen is overseen by the main cook. There is a well-equipped kitchen and all meals are cooked onsite. There is a separate dining room in each area. Meals are plated from a Bain Marie in each unit. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of</p>

		<p>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 documented daily, and these were 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 menus have been audited and approved by an external dietitian. Residents and families interviewed were very happy with meals provided.</p> <p>There was evidence that there are additional nutritious snacks available over 24 hours.</p> <p>Partial Provisional audit: The kitchen is well equipped and staffed to provide a meal service for the new refurbished wing and for the residents who will reside there.</p>
<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>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. 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 if entry were declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The facility has embedded the InterRAI assessment protocols within its current documentation. Bupa assessment booklets and care plan templates were comprehensively completed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all files. The assessment booklet provides in-depth assessment across all domains of care and is an add-on to the InterRAI assessment. Risk assessments are completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, wound care and restraint were appropriately completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans were comprehensive, and demonstrate service integration and input from allied health. All resident care plans sampled were resident centred and support needs were documented in detail. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans in the psychogeriatric unit 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 or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals. Psycho-geriatrician support and advice is documented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>All care plans reviewed included documentation that meets the need of the residents. Where resident needs had changed, care plans had been updated. Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members agreed that the clinical care is good and that they are involved in the care planning. Caregivers and RNs interviewed state there is adequate equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. Wound management and monitoring occurred as planned. All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Care plans document allied health input. There are three wound registers in the facility, which included 11 wounds currently managed (three pressure wounds). Monitoring occurs for weight and vital signs, blood glucose, pain, food and fluid on monitoring charts and integrate with the care plans.</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 are three activities coordinators; each works between 35 and 40 hours per week. On the day of the audit, one activities coordinator has resigned two days earlier. Activities were being provided by caregivers that temporarily filled in for the absent activities coordinator. A contracted physiotherapist assists with the exercise and walking groups. A physio assistant assists with walking, mobility and transfer. The activities coordinator for the psychogeriatric unit has received training around dementia care and needs. On the day of audit, residents in all</p>

		<p>areas were observed being actively involved with a variety of activities. Residents and family interviewed were satisfied with the activities programme and the recent extension of activity hours over the weekends. The Bupa activities programme template is designed for high end and low end cognitive function and caters for individual needs. The programme is developed monthly and is displayed in large print. 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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses' six monthly or when changes to care occurred. 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 and resident/family. The family are notified of the outcome of the review by phone call 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. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<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 clinical manager identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services.</p>
<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</p>	FA	<p>Certification: There are implemented policies to guide staff in waste management, including general and medical waste. 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</p>

<p>substances, generated during service delivery.</p>		<p>services. Safety data sheets and product sheets are available. Hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. The maintenance person described the safe management of hazardous material. Gloves, aprons and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. The cleaners store chemicals in a caddy, which they take with them when cleaning.</p> <p>Partial Provisional: Chemicals are stored securely in a locked storage area in the unit. Personal protective equipment is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building holds a current warrant of fitness, which expires on 1 January 2016. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a 52 week planned maintenance programme in place. Hot water temperature has been monitored fortnightly in resident areas, with some recordings noted to be above the acceptable limits. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. 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 existing 20 bed Palmside psychogeriatric unit is secure. There is a secure internal courtyard developed for the psychogeriatric unit. The facility has a van available for transportation of residents. Staff transporting residents holds a current first aid certificate.</p> <p>In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. There are outside areas that include seating and shade around the facility. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required.</p> <p>Partial Provisional: Refurbishment of the Barrington psychogeriatric unit is yet to be completed. The 24 single bedrooms in the unit do not require refurbishment. The area under construction includes remodelling of the lounge and dining area, a new nurse's station, a new treatment room and secure doors are to be added. It is the intention of</p>

		<p>the service to initially utilise half of the unit. This area includes 12 single bedrooms with full ensuite facilities, the lounge/dining area, the nurses station and the treatment room. This area is unoccupied. There are currently 12 hospital level residents accommodated in the other half of the unit. These rooms will be included in the secure psychogeriatric unit as required. There is a secure internal courtyard which residents will be able to access. The external area of the unit can be accessed via a door and this area is not yet secure. The service has one standing and one sling hoist available for the Barrington unit. Existing equipment, furniture and fittings in resident areas, is appropriate to the needs of psychogeriatric residents.</p>
<p>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.</p>	<p>FA</p>	<p>There are adequate toilets and showers in the rest home, hospital and existing psychogeriatric unit. Resident rooms in the psychogeriatric unit and hospital have hand basins and ensuite facilities. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. 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>Partial Provisional: The 24 bed Barrington psychogeriatric unit has sufficient numbers of toilets and showers. Twelve rooms have full ensuite and are part of the initial 12 bed unit. The remaining 12 rooms have communal toilet and shower facilities including two showers and two toilets.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Certification: All residents rooms are single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuite. Residents have been encouraged to personalise their bedrooms. The open plan lounge areas are spacious and can be used for activities and small groups, as well as for private social interaction. Residents requiring transportation between rooms or services are able to be moved safely from one area to another. Bedrooms are large enough to include a lazy boy chair and extra equipment if required. Staff interviewed reported that they have adequate space to provide cares to residents.</p> <p>Partial Provisional: All rooms in the 24 bed Barrington psychogeriatric unit are of sufficient size to allow care to be provided and for the safe</p>

		use of mobility and transfer aids.
<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>	PA Low	<p>Certification: Activities occur throughout the facility and in the lounge areas. All communal rooms are large enough to not impact on other residents not involved in activities. Seating and space is arranged to allow both individual and group activities to occur. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p> <p>Partial Provisional: Areas of the Barrington unit are currently being remodelled. There is a large lounge and dining area, a nurse's station and a treatment room included in the remodelling.</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>Certification: All laundry is undertaken on site by a contracted company. The laundry is well organised and is divided into a "dirty" and "clean" area and staff manage the workload adequately. Laundry from three other sites is also processed at Cashmere View. There are appropriate systems for managing infectious laundry, which laundry staff could describe. There is a comprehensive laundry 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 days of the audit. There is a sluice room in each part of the facility for the disposal of soiled water or waste.</p> <p>Partial Provisional: The residents' laundry from the Barrington psychogeriatric unit will be managed by the contracted company. There will be no increase in the number of residents in the service. Laundry services will be maintained to the current standard for new residents.</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>	PA Low	<p>Certification: There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are 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 are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. There are four civil defence kits (wheelie bins) in the facility and stored water. Call</p>

		<p>bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is secured at night.</p> <p>Partial Provisional: It is planned that existing staff who are trained in first aid and emergency management will staff the Barrington unit. The fire evacuation scheme for Cashmere View was approved in October 2014 following the completion of the Ashgrove rest home/hospital wing. The scheme will require amendment following the 24 bed Barrington unit becoming a secure and locked psychogeriatric unit. Security arrangements will continue as current. The call bell system in the Barrington unit is working. A central panel and pager system alerts staff to the area where the call bell has been activated.</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>Certification: General living areas and resident rooms are appropriately heated and ventilated. The facility has plenty of natural light. All residents interviewed stated they were happy with the temperature of the facility. Smoking is only allowed outside and away from the facility.</p> <p>Partial Provisional: The unit is heated via overhead heating panels. Heating in each bedroom can be adjusted to personal comfort levels. All rooms have external windows.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Certification and Partial Provisional: The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and infection control programme description is available. The infection control officer is a registered nurse. There is a job description for the infection control (IC) officer and clearly defined guidelines. The infection control programme is linked into the quality management programme. The infection control committee meets monthly. The quality meetings reviewed also included a discussion of infection control matters. The IC programme is reviewed annually at head office. Annual quality and infection control goals are set at the beginning of the year. The facility has developed links with the GP's, local laboratory, and 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. The facility had a norovirus outbreak in June 2014, which was reported to the appropriate designated agencies. An outbreak case log documented all elements of the investigation and control activities, communication with relatives and</p>

		residents and evaluated outcomes.
<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>	FA	The infection control committee is made up of a cross section of staff from all areas of the service including (but not limited to), the care home manager, the clinical nurse manager, IC officer (RN), an RN, a household staff member and an activities staff member. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.
<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 provided.</p>	FA	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, 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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control officer is responsible for coordinating/providing education and training to staff. The IC officer (RN) 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. Toolbox 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>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	The surveillance policy describes the purpose and methodology for the surveillance of infections. The IC officer 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 officer. Infection control data is collated monthly

		and reported at the quality and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme (link 1.2.3.6). The results are subsequently included in the manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.
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, which reviews restraint practices. The Cashmere View 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 restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures. There were three hospital residents with enablers; two lap belts while in wheelchairs and one with bedrails. There were a total of six residents on restraint; four hospital and two psychogeriatric residents. Three hospital residents had bedrails and one hospital resident had a lap belt. Two psychogeriatric residents had lap belts. All restraint and enabler use was recorded on a restraint register. Files for three hospital residents and one psychogeriatric resident 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, 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	A registered nurse is the restraint coordinator. 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. Restraint use and review conducted at restraint meetings and report to the quality team meeting.
Standard 2.2.2: Assessment	FA	The service completes comprehensive assessments for residents who require restraint interventions. These were undertaken by suitably

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>qualified and skilled staff in partnership with the family/whānau. 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 consent forms were fully completed. These were sighted in the four files reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual 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 restraint files reviewed. The restraint coordinator was interviewed. 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 was updated each month.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the four restraint files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices were reviewed on a formal basis every month by the facility restraint coordinator at restraint meetings, quality and staff meetings. Evaluation timeframes were determined by risk levels. The evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review 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 coordinator and/or clinical manager. Any adverse outcomes were included in the restraint coordinators monthly reports and were reported at the monthly meetings. Restraint use is also reviewed as part of the quality team meeting.</p>

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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>Five complaints received for 2015 evidence that appropriate follow up and response was initiated within the expected time frames. Outcomes from investigations have included staff feedback, staff training and performance management where required. Toolbox talks have been initiated with staff to reduce incidence of repeat complaints. A resident interviewed advised that follow up on a written complaint had not been provided. It was identified that the complaint had been misplaced on the manager’s desk and this was addressed during the audit.</p>	<p>One written complaint from June 2015 has not been responded to, as advised by the complainant.</p>	<p>Ensure that all complaints are responded to within service policy timeframes.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan,</p>	PA Low	<p>Certification: The clinical manager maintains a competency spreadsheet for all staff. Education sessions are</p>	<p>Certification: Two caregivers who work in the psychogeriatric unit have not completed the required</p>	<p>Certification: Ensure that all care staff who work in the psychogeriatric unit/s</p>

<p>facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>provided at least weekly in the form of face to face in-service sessions, self-directed learning, tool box talks, and attendance at external training sessions. A number of staff have attended and completed a dementia specific external training course. There are 16 caregivers who work in the psychogeriatric unit and two activities assistants, who work in the psychogeriatric unit. Fourteen of 16 caregivers and two activities staff have completed the required dementia unit standards.</p>	<p>dementia unit standards. Both have been employed for longer than 12 months.</p>	<p>have completed the required dementia unit standards within 12 months of employment.</p> <p>90 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>Partial Provisional audit: The facility has comprehensive policies and procedures in place for all aspects of medication management. There is a separate medication trolley for each unit in the facility.</p> <p>There are up to date staff signatures on file and medication incidents are followed through and actioned</p> <p>. Medications requiring refrigeration are monitored and temperatures have been documented regularly. The service uses the robotic system in all levels of care and the pharmacy provides these fortnightly.</p>	<p>Partial Provisional audit: On the day of the audit the treatment room in the refurbished unit was not completed to evidence secure safe storage for medication.</p>	<p>Partial Provisional audit: Ensure that there is provision of secure medication storage in the treatment room in the new psychogeriatric unit.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Certification: Hot water temperature monitoring policies and procedures are in place. Policy states that temperatures in resident areas are to be maintained at 45 degrees Celsius or below. The policy also states that</p>	<p>Certification: Corrective actions have not been documented or implemented where hot water temperatures have been recorded over the acceptable limit of 45 degrees Celsius. There have been</p>	<p>Certification: Ensure that where hot water is recorded as over the required limit of 45 degrees Celsius, the service can evidence that</p>

		corrective actions are to be implemented where temperatures are outside this limit. Records for 2015 were reviewed. Temperatures have been monitored for room temperatures, kitchen hot water and resident area hot water. Temperatures were noted to be over 45 degrees on nine occasions.	nine occasions in the past eight months where hot water temperatures have been recorded between 46 - 48 degrees.	corrective actions are taken to rectify the issue. 60 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	Partial Provisional: The Barrington psychogeriatric unit is currently being refurbished. The service intends to utilise 12 single full ensuite resident rooms initially. This 12 bed unit will include a lounge and dining area, a nurse's station, a treatment room and will have key pad entry and exit. The doors to this area are in place but are not yet able to be secured. It is the intention of the service to secure the remaining 12 bedrooms within the unit as the need arises.	Partial Provisional: The Barrington psychogeriatric unit is not yet a secure unit.	Partial Provisional: Ensure that the Barrington unit is secure at each stage of the project for the initial 12 bed unit and when the remaining the 12 beds are included in the 24 bed unit. Prior to occupancy days
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	Partial Provisional: There is an internal courtyard which will be included in the initial 12 bed unit. This can be accessed and is secure. There is a door, which opens to the external garden area, which is not secure. Advised by the service that the plan is to construct a fence and locked gate system to enclose the external garden area securely.	Partial Provisional: The external garden area is not secure. The door leading to the outside is not secure.	Partial Provisional: Ensure that all external areas are secure and safe for residents. Prior to occupancy days
Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge,	PA Low	Partial Provisional: The Barrington unit (when completed) will have a large lounge area and a large dining area.	Partial Provisional: Remodelling of the dining area and lounge areas have not yet been completed	Partial Provisional: Ensure there is provision of a lounge area and dining

playroom, visitor, and dining facilities to meet the needs of consumers.		This will be included in the initial 12 bed unit.		area for residents. Prior to occupancy days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	Partial Provisional: The fire evacuation scheme was approved in October 2014. The refurbishment and internal remodelling of the Barrington unit has not included any changes to the floor plan or layout of the wings. The unit will be secured prior to occupancy of psychogeriatric residents (link #1.4.2.4).	Partial Provisional: Currently the Bupa property team are getting advice from the fire systems contractors regarding whether an amendment is required to the current fire evacuation plan.	Partial Provisional: Provide evidence that the fire evacuation scheme has been amended if required. 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.

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 quality and risk management systems continue to be well implemented at Cashmere View. The framework ensures services adhere to the health and disability services standards. There are required actions being implemented when outcomes do not meet targets. Corrective action plans are implemented and closed out and staff are involved in quality initiatives. Bupa has a strong focus on clinical benchmarking, both nationally and internationally.</p> <p>External training is supported, with evidence of attendance in staff files reviewed and verified through staff interview. ‘Tool box’ sessions, which are focused discussions with staff following for example a particular incident, are also seen to be provided regularly at Cashmere View. All caregivers are required to complete foundations level two as part of orientation. There are implemented competencies for</p>	<p>Bupa has a robust quality and risk framework that is being implemented at Cashmere View. The framework includes standardised policies; an education programme including core competencies for different staff groups; an internal audit and corrective action planning process; benchmarking against similar services types; centralised management of complaints and internal investigation following category one incidents; and surveys (resident/relative and staff). There is a prescribed meeting schedule for services that is also seen to be implemented at Cashmere View.</p> <p>The annual education programme prescribed for the organisation is being implemented at Cashmere View. Where attendance at a prescribed in-service is below expected, either a ‘toolbox’ session or additional in-service is provided. Toolbox sessions</p>

		<p>caregivers, enrolled nurses and registered nurses.</p> <p>The Bupa "personal best" initiative is being implemented. This programme is being facilitated by senior care staff.</p>	<p>are a regular part of Cashmere View practice and are held in response to either an issue or a planned improvement. Examples of toolbox talks include safe manual handling, use of hip protectors, conducting observations and preventing pressure injuries. Bupa have competency assessments for different staff types such as RN, caregivers and these are current at Cashmere View. In order to ensure competency assessments remain current a spreadsheet is maintained by the care home manager and clinical manager. Cashmere View supports staff to attend external training. From an organisational perspective, Bupa provides a bi-monthly clinical newsletter called Bupa Nurse providing forum to explore clinical issues and updates with all qualified nurses in the company and the Bupa geriatrician provides newsletters to general practitioners.</p> <p>Bupa's internal audit programme continues to be implemented at Cashmere View. Where an internal audit result is less than 100% a corrective action plan has consistently been developed and closed out. Internal audits are delegated to various staff to encourage participation in a quality improvement programme. Clinical file review is part of the audit programme and interview with staff confirm they are involved in corrective actions when improvements are required.</p> <p>Services are benchmarked by service type, with Cashmere View being benchmarked against psychogeriatric, rest home and hospital care. Corrective action plans are developed when rates exceed expectation. Of note is the current focus on reducing the incidence of bruising, reducing falls rates, reducing urinary tract infections, and reducing pressure injuries. Areas of improvement are noted for 2015 with a reduction in skin tears for hospital and psychogeriatric residents and a</p>
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			<p>reduction in the rate of falls for rest home residents.</p> <p>Meetings are held regularly and minutes reviewed include discussion about key aspects of care delivery and emerging trends resulting from benchmarking. Data is graphed and available in the staff room. Corrective action planning results where trends are above a target, and there is evidence of a reduction in resident incidents results (also refer 1.2.3.6). Outstanding matters are seen to have been followed through to the next meeting.</p> <p>Bupa has a "personal best" initiative where staff undertake a project to benefit or enhance the life of a resident(s). Of the 43 care staff at Cashmere View, 60% have achieved bronze, 35% have achieved silver and 23% have achieved gold. Examples evidence improvement to residents' daily life and residents provide feedback to management in regard to personal bests that have impacted on their lives.</p> <p>Bupa has leadership development of qualified staff including education from HR, attendance at external education and Bupa qualified nurses' education day and education session at monthly meetings.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>Quality improvement data has been collated monthly and reported to head office. Complaint activity, internal audit outcomes and CAP activity has also been reported. There is a prescribed meeting schedule that was being implemented at Cashmere View that included monthly quality meetings, full facility staff meetings, health and safety and infection control. Key components of the quality system have been discussed. Annual quality goals have been developed for each area of service including kitchen,</p>	<p>Clinical indicator data for Cashmere View includes clinical indicators such as skin tears, falls, medication errors, bruising, resident behaviours, and restraint and pressure injuries. Incident rates are calculated on a per 1,000 occupied bed days with an acceptable rate calculated for each clinical indicator. The following improvements have been noted for the year to date for rest home, hospital and psychogeriatric residents.</p> <p>Rest home: No medication errors or incidents have</p>

		<p>activities, infection control, maintenance, clinical management, health and safety and physiotherapy. Annual goals for clinical include reducing pressure injuries by 20%, reducing falls rates by 10%, reducing bruising by 20% and reducing urinary tract infections. Monthly clinical indicator data has been collated across the facility monitoring rest home, hospital and psychogeriatric services. There is evidence of trending of clinical data and the development of CAPs when volumes exceed targets. There are falls prevention strategies in place that include, hi/lo beds, ongoing falls assessment and exercises by the physiotherapist and sensor mats. Interview with staff confirmed an understanding of the quality programme. Bupa has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Actions include an analysis of 2014 incidents, toolbox talks on manual handling, inclusion of the physiotherapist in the education programme for safe manual handling, and education sessions for staff regarding reducing bruising incidents, of which 26 staff attended. Month by month progress is being tracked. Quality Action Forms (QAF) are implemented in response to a facility quality initiative. The service was able to evidence that improvements have been made in response to quality initiatives. There is a health and safety and risk management programme being implemented at Cashmere View. The health and safety committee meet monthly and minutes reviewed included discussion of incidents/accidents. There are safety representative who has attended training. There was a current hazard register.</p>	<p>been noted for 2015. Falls rates (expected rate of 7 or below) have been reducing since January 2015 when the rate was at 12, February – 12, March – 8, April – 2, May – 3, June – 3, and July – 3.</p> <p>Psychogeriatric: The incidence of skin tears (expected rate of 6 or below) has been reducing with a rate of 5 for January, February – 9, March – 8, April – 2, May – 3, June – 2 and July – 0.</p> <p>Hospital: Again the incidence of skin tears has reduced from 5 in January, February – 3, March – 3, April – 4, May – 2, June – 3 and July – 0.</p>
<p>Criterion 1.2.3.7 A process to measure</p>	<p>CI</p>	<p>Cashmere View has a Quality and Risk meeting schedule with meetings being held monthly. All</p>	<p>At the beginning of each year the quality team formulate goals for the year which are fed back to</p>

<p>achievement against the quality and risk management plan is implemented.</p>		<p>interested parties are invited to attend and reports are received from all heads of department. The findings from this meeting are then relayed via the minutes on the notice board in the staff area and at the monthly staff meeting.</p> <p>Audit results which form a large part of the quality maintenance system are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. Results are then fed back to staff at appropriate forums, e.g. quality meeting, resident and staff meeting.</p>	<p>the governing body for monitoring and review. These are evaluated and discussed at the monthly meetings with a report being generated back to the governing body three monthly. If the goals are not being achieved further corrective action plans are developed and are highlighted to the staff via the staff meeting.</p> <p>An example of this was the goal in 2014 “To decrease Grade 2 or greater, pressure injury by 10% within the hospital and PG units”. This was discussed at quality meetings and strategies put in place to achieve the goal. This was monitored and evaluated monthly with reports to Quality Management Coordinator for Bupa, 3 monthly. Unfortunately the strategies were unsuccessful but the evaluation of these showed reasons contributing to the non-achievement. This quality goal has been rolled over to 2015 where the initiatives are proving successful and an achievement of this target is on track.</p> <p>Further new goals have been developed for 2015 including (but not limited to); “To try and reduce the amount of falls reported in the hospital wings by 10% while continuing to maintain independence”. Strategies to achieve this have been developed and instigated. Progress has shown the effectiveness of these strategies and has been reported back to the governing body. January 2015 report of 15 falls compared to 13 in January 2014. Toolbox on footwear held, and two toolbox talks to discuss use of hip protectors. In May, GP completed medication reviews of repeat fallers. Footwear checked by RN and Physio prior to walking. Shoes purchased for one resident. Activities classes were attended by several residents. Quotes for foot pedal equipment requested x 2. Hand weights purchased also. In June, a total of eight falls across both hospital</p>
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			<p>wings were reported this is a decrease from 16 in the last 2 months. Ongoing progress reporting of quality goals and re-evaluation of strategies identified a great reduction in falls from the 2014 stats. The service continues to focus on keeping up referrals and falls prevention initiatives such as (but not limited to), footwear, hazard identification, use of physio and exercise programmes. Residents and relatives were kept informed through newsletters and meetings. The management team reported that overall the development of goals that are achievable, measurable and improve the life of their resident's is fundamental to the quality initiatives the service develops and implements.</p>
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End of the report.