Bupa Care Services NZ Limited - Bethesda Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Bethesda Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 September 2015 End date: 4 September 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 85

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bethesda Home and Hospital is part of the Bupa group. The service is certified to provide rest home and hospital level care for up to 91 residents. On the day of audit, there were 85 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

An aged care facility manager (RN) manager who is appropriately qualified and experienced manages Bethesda Home and Hospital. She is supported by a clinical manager, rest home and hospital unit coordinators and a Bupa regional manager. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service, including residents that require hospital/medical, and rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to Bethesda. Quality initiatives are implemented which provide evidence of improved services for residents.

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

The facility has embedded the InterRAI assessment protocols within its current documentation. Bupa assessment booklets and care plan were individualised and comprehensively completed for all resident files reviewed. 'At risk' residents were identified and monitoring strategies were implemented and regularly evaluated.

There has been a number of environmental improvements since previous audit with refurbishment in some communal bathrooms, lounges and resident rooms.

The service is commended for maintaining and achieving five continual improvement ratings relating to good practice, implementation of the quality system, and activities.

One improvement has been identified around documentation of communication in relation to advance directives.

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.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		All standards applicable to this service fully attained with some standards exceeded.

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

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

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, 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.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

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. Appropriate training, information and equipment for responding to emergencies are provided. Housekeeping staff maintain a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. All laundry is completed off-site at another Bupa facility.

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.

Bethesda Home and Hospital had no restraints in use on the day of audit. Enablers are voluntary and the least restrictive option. There was one resident who required an enabler on the day of audit.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating/providing education and training for staff. The Bupa quality and risk team supports the infection control coordinator. 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 ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	4	40	0	1	0	0	0
Criteria	5	87	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (six caregivers, one enrolled nurse, four registered nurses, two unit coordinators, care home manager, clinical manager, one activity assistant, one diversional therapist), reflected their understanding of the key principles of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low	The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident in all 10 resident files reviewed. However, there was no documented evidence of general practitioner (GP) and family discussion regarding a clinically 'not indicated' resuscitation status. General consent forms were evident in the 10 files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney evidence is sought prior to admission, and activation documentation is obtained and both 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.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. This includes residents' visits to the local mall, visiting the library and attending community celebrations (link 1.3.7.1). Resident/family meetings are held quarterly.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. The facility manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation including follow up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are in a visible location at the entrance to the facility. Three complaints received in 2015 were reviewed with evidence of appropriate follow-up actions taken. There is currently one HDC complaint (May 15) in progress.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the quarterly resident/family meetings. All eleven residents (six rest home level and five hospital level) and nine relatives (six rest home level, three hospital level) interviewed, report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents' preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held each week. There is a policy on abuse and neglect and staff have received training.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. During this audit there was one Māori resident living at the facility. Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. The facility's residents are from a variety of cultures. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. Two general practitioners (GPs) visit the facility once a week. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site, ten hours per week. There is a regular in-service education and training programme for staff. A podiatrist is onsite every six-weeks. The service has links with the local community and encourages residents to remain independent. Bupa has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. Bethesda is benchmarked against the rest home and hospital data. If the results are above the benchmark, a corrective action plan is developed by the service. Bethesda reviewed their 2014 quality plan and carried their unmet quality goals over to 2015. Detailed CAPs to achieve the unmet goals were implemented, regularly evaluated. Progress toward the identified goals were regularly communicated to staff and residents. The interventions implemented, resulted in a reduction of facility acquired pressure injuries, eye infections and skin tears. The GP interviewed is satisfied with the level of care that is being provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Nine accident/incident forms reviewed (from August), identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The residents and

		family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	CI	Bethesda Rest Home and Hospital is a Bupa residential care facility. The service currently provides care for up to 91 residents at hospital and rest home level care. On the day of the audit there were 44 hospital level residents including one resident on a younger persons with disabilities contract, and one resident on an end of life contract. There were 44 rest home residents including one resident on a respite care contract and one resident on an ACC short-term contract. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. The care home manager is a registered nurse with a current practising certificate who has been in this role for nine years. She is supported by a clinical manager who has worked at Bethesda for 3.5 years and has been in the role of clinical manager for five months. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service. There is a regular review of the quality goals at the site and organisational level.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The care home manager is supported by a clinical manager/registered nurse (RN) who is employed full time and steps in when the care home manager is absent. The clinical manager has been in the role for five months and prior to this had been working for 3.5 years as an RN at Bethesda. The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk	CI	A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in

management system that reflects continuous quality improvement principles.		place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Nine accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Incidents are benchmarked and analysed for trends (link 1.2.3.6). The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Two resident deaths (including a resident under the mental health act) has been referred to the coroner and an appropriate Section 31 notification has been made for another incident. Public Health has been notified of a recent respiratory outbreak.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are buddied for a period of time (eg, caregivers two weeks, RN four weeks), and during this period they do not carry a clinical load. The caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this, they are then able to continue with Core Competencies Level 3 unit

		standards. These align with Bupa policy and procedures. All caregivers have completed career force level one. Twenty-five caregivers are enrolled in Careerforce. Seven caregivers have completed Careerforce dementia modules. Numeracy & literacy is offered at no charge to those who have an identified need and those who request support. Bupa has a comprehensive annual education schedule. All staff are encouraged to attend at least 12 sessions a year, including compulsory sessions. There is an annual education and training schedule that is being implemented. Opportunistic education is provided via toolbox talks. The caregivers undertake aged Care Education (ACE). Education and training for clinical staff is linked to external education provided by the district health board. Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has recently approved and validated their PDRP for five years. Bupa takes over the responsibility for auditing their qualified nurses. At Bethesda, three RNs have completed their portfolio on the Bupa Nursing Council approved PDRP. Eight RN's are InterRAI trained. Four RNs have completed the Leading to Bupa 2020 Leadership course. The CDHB GNS offers education for clinical staff at the hospital. A competency programme is in place with different requirements according to work type (eg, support work, registered nurse, and cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. RN competencies include assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing levels meet contractual requirements. The care home manager and clinical manager are registered nurses and share the on-call after hours with other registered nurses. The care home manager and clinical manager are available during weekdays. There is also a unit manager in the rest home and one in the hospital (both RNs). Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers supports RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory. The manager advised they are currently recruiting more casual staff to assist when staff are sick.
Standard 1.2.9: Consumer Information Management Systems	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	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. 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. One rest home file was reviewed of a resident that had been transferred to hospital acutely. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The service utilises two-weekly robotic packs. There is a medication room in the hospital and locked cupboard in the rest home nurses office. 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 IDs. 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 GPs. 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. 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. Pharmacy audits are completed by the pharmacy annually.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a large workable kitchen. There is a preparation area and receiving area. Kitchen fridge, food and freezer temperatures are monitored and documented daily. There are a number audits completed including; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit. Internal audits reviewed included implemented action plans, where required. Residents' food preferences are identified on admission. This includes consideration of any particular dietary preferences or needs (including cultural needs). Likes and dislikes are kept in the kitchen. Advised that residents can have breakfast in their room. There is a satisfaction survey, which includes meals satisfaction, completed annually. All nine family members and 11 residents interviewed were complimentary about the food service. The national menus have been audited and approved by an external dietitian. All kitchen staff have completed an HSI Food Services course. The cook has completed level two. All staff have had the opportunity to attend nutrition related education: Choking of resident, safe food – September 2013; fluid intake – August 2013. The 2015 resident's satisfaction survey showed a decrease in satisfaction with the food service, specifically that some of the residents were not satisfied with the temperature of the meals being served in one of their dining rooms. This issue was discussed in both the quality and clinical meetings and as part of the corrective action plan, although regular monitoring of food temperatures is recorded, the cook and the kitchen assistant introduced a step where they sample the main meal every day to ensure they are the correct temperature. Meals for this particular dining room are now dished first and are delivered with food covers. The care staff have access to a microwave in that dining room where they can also reheat the meal if the resident is still not satisfied with the temperature. Following these changes it was discussed in the April residents meeting and the residents reported the temperatures are much better now.
Standard 1.3.2: Declining Referral/Entry To Services	FA	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

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.		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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	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. Files reviewed across the rest home and hospital identified that risk assessments have been 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.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed 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. Two residents had specific 'End of Life' care plans in place. 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.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans reviewed included documentation that meets the need of the residents. The respite files reviewed (rest home) included a specific short stay nursing assessment and care plan. 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 interviewed stated care and support 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 were two wound registers in the facility. In the

		hospital, the register included 10 wounds including three (grade 1 & 2) pressure wounds. In the rest home, the register included 14 wounds including one (grade 2) pressure wound. All wounds included an assessment, management plan and ongoing evaluation. A sample of wounds reviewed in detail included a link to STCPs and LTCPs. There is wound care specialist input into two chronic ulcers. Monitoring charts were well utilised at Bethesda and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts, behaviour monitoring integrate with the care plans
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	Bethesda employs one trained diversional therapist and three activities assistants. They are supported by the Bupa occupational therapist, based in Christchurch. There are several programmes running that are meaningful and reflect ordinary patterns of life. The programme is developed monthly and displayed in large print. Residents have a complete assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc. and information from this is fed into the lifestyle plan. A record is kept of individual residents activities. There are recreational progress notes in the resident's file that the activity staff completes for each resident every month. Each resident has a 'map of life'. The resident/family/whānau as appropriate is involved in the development of the activity plan. The service is part of a Bupa Activity Pilot Programme aiming at offering more meaningful activities. Resident files reviewed identified that the individual activity plan is reviewed when at care plan review and it is evaluated.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	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 ongoing 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.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		resident was reassessed for a higher or different level of care. Discussion with the clinical manager and two unit managers identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are 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 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires on 21 December 2015. 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 regularly in resident areas. The corridors are wide and promote safe mobility for 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 facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate. Since previous audit, the service has refurbished some of the bedrooms, the Camilla lounge/dining room in the rest home, the hospital servery and staff room, the hospital wing nurses' station and treatment room, three bathrooms and two toilets in the hospital wing.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing	FA	There are adequate toilets and showers in the rest home and hospital. The majority of rooms in the rest home have full ensuites. The hospital has a mix of rooms with ensuites and shared communal bathrooms. 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

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		towels. Communal toilets and bathrooms have appropriate signage and locks on the doors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Throughout, the rest home and hospital, resident rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Residents requiring transportation between rooms or services can be moved from their room by either trolley or wheelchair.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are several lounges throughout the facility and also combined lounge/dining rooms in both the rest home and hospital. Residents and assistants are able to move freely. Activities occur throughout the facility.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry services are well monitored throughout the internal auditing system. Laundry has been outsourced to Cashmere View and dirty linen is collected daily and clean linen returned daily. Laundry has a clean/dirty flow and chemicals are stored securely. Staff receive training at orientation and through the in-service programme. There is appropriate policy and product charts (Johnson Diversey). Cleaning rooms are locked when not in use. Laundry service satisfaction is included in the annual survey. Residents and relatives reported satisfaction with the laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response	FA	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 civil defence kits in the facility and stored water. Call bells are evident in

during emergency and security situations.		residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	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.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator is a registered nurse (CM) and she is responsible for infection control across the facility. The committee and the Bupa governing body in conjunction with Bug Control, is responsible for the development of the infection control programme and its review. A lower north/southern regional infection control meeting addresses infection control issues across the organisation. These are documented in the IC file and the IC coordinator Bethesda attends via teleconference. The infection control programme is well established at Bethesda. The quality/infection control committee consists of a cross section of staff and there is external input as required from general practitioners, CDHB and Southern Community Laboratory. A recent suspected respiratory infection was well managed in the hospital.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Bethesda. The infection control (IC) nurse has maintained best practice by attending infection control updates. The infection control team (the quality team) is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available
Standard 3.3: Policies and procedures Documented policies and	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand washing and standard precautions. An IC consultant completed training on infection control July 2015. The infection control coordinator has received education both in-house and by an external provider to enhance her skills and knowledge. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking. A number of toolbox talks have been provided including (but not limited to), preventing UTIs and chest infection management.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and southern community laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark (link 1.2.3.7). All infections are documented monthly in an infection control register. A monthly infection control report

		is completed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had no residents using restraint and one resident with bedrails as an enabler documented. All enabler use is voluntary. The restraint/enabler assessment form was completed, with input from the RN and GP and the resident's family and this was documented in the file of the resident who was using an enabler. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	Completed resuscitation treatment plan forms were evident on all 10 resident files reviewed. The unit managers interviewed, described discussing any GP clinical decision regarding ‘Do Not Resuscitate’ with the families during the initial care planning meeting. Informed consent forms and resuscitation decisions are also included in MDT reviews. However, there was no documented evidence of general practitioner (GP) and family discussion regarding a clinically ‘not indicated’ resuscitation status as per policy.	There was no documented evidence of general practitioner (GP) and family discussion regarding a clinically ‘not indicated’ resuscitation status as per policy.	Ensure there is documented evidence that relatives are informed of any clinically ‘not indicated’ resuscitation status. 90 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
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A policy and procedure review committee (group) meets monthly to discuss the policies identified for the next two policy rollouts. At this meeting, policy review/development request forms from	Bupa has robust quality and risk management systems and these are implemented at Bethesda, supported by a number of meetings held on a regular basis. Quality improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Bethesda through toolbox talks (sighted). Education is supported for all staff and a number of caregivers have enrolled or completed a national qualification. There are two Careerforce assessors (RNs) at Bethesda. Twenty-five caregivers are enrolled in Careerforce. Seven caregivers have completed Careerforce dementia modules. The organisation has introduced leadership development of qualified staff education from HR, attendance at external education and Bupa qualified nurse’s education day and education session at monthly meeting. Four RNs at Bethesda have completed the Leading to Bupa 2020 Leadership course. Eight RN’s are InterRAI trained. InterRAI is fully implemented at Bethesda. PDRP - All qualified staff are encouraged to complete at least ‘competent’ level. The service currently

		staff are tabled and priority for review is decided. The group members are asked to feedback on changes to policy and procedure which are forwarded to the chair of this committee and commonly also to the quality and risk team. Finalised versions include feedback (where appropriate) from the committee and other technical experts. There is a human resources learning and development fund policy. The objective of this policy is to ensure the ongoing learning and development of all employees. The policy identifies funding available through Bupa for three staff categories; a) registered nurses - post-graduate clinical studies, b) leadership and management skill development and c) enrolled nurses and nurse assistants. Bupa has a bi-monthly clinical newsletter called Bupa Nurse, which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. Registered nurse interviewed at Bethesda could describe this. Competencies are completed for key nursing skills. Registered nurses regularly access training, including sessions that are externally run. Bupa run a registered/enrolled nurse training day and clinically focused training sessions. Bupa has a residents/relatives association in order to provide a more strategic forum for news, developments and quality initiatives for the Bupa group to be communicated to a wider consumer population. This group continues to meet every three months and involves members	has three RNs who have been assessed at competent level. Review of resident files including care plans, interview with residents and relatives, the GP and registered nurses identified competent clinical oversite and support. Bethesda is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans (CAP) are established when above the benchmark for example, March 2015, skin tears in the hospital were high, a CAP was implemented. The effectiveness of the CAP was evaluated, which identified an improvement in the number of skin tears over the next three months. Toolbox talks are routinely completed that link to benchmarking indicators in each of the two areas at Bethesda. Quality action forms are also established for areas that staff/management identify as requiring improvement. A quality action form was established June 2015, as a result of increased falls in the rest home. A 'fall alert' section was added to the resident/relative newsletter to update residents around when fall rates are high. This report includes tips on how to prevent falls. Graphs and notices were also sighted on resident noticeboards. An evaluation of this quality action identified falls had dropped from 16 in July to four in August. Bethesda reviewed their 2014 quality goals and identified that they had not met the annual targets/goals they had set in relation to eye infections. These quality targets were carried over to 2015. A corrective action plan was put in place and communicated to staff. Progress toward the achievement of these goals was communicated at resident and staff meetings and updates placed on site notice boards. CAPS were reviewed monthly at staff meetings and the monthly indicator data was analysed and discussed. There has been a reduction in the incidence of eye infections over the facility from January to August 2015. The incidence of eye infections was reduced to the Bupa benchmark.

		of the executive team including the chief executive officer, general manager quality and risk and consultant geriatrician. Newsletters are available for residents and relatives at Bethesda. Discussions with eleven residents (five hospital and six rest home) and nine relatives (three hospital and six rest home) were very positive about the care they receive. All services provided at Bethesda adhere to the health and disability services standards. There are implemented competencies for care workers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions	
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	Bethesda is part of the southern Bupa region and the managers from this region meet quarterly to review and discuss the organisational goals and their progress towards these. The care home manager provides a weekly report to the Bupa operations manager. The operations manager teleconferences the southern managers weekly and completes a report to the director of care homes and rehabilitation. A quarterly report is prepared by the care home manager and sent to the Bupa Quality and Risk Team on the progress and actions that have been taken to achieve the Bethesda quality goals. Bupa has robust quality and risk management systems implemented across	The organisational and quality goals are reviewed regularly at the site and at organisational level. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Bethesda, and forwarded to the Bupa and risk team. Meeting minutes reviewed included discussing ongoing progress to meeting their goals. Bethesda annual goals also link to the organisations goals and this is reviewed in quality meetings and also in each of the staff/other meetings. This provides evidence that the quality goals are a 'living document'. Bethesda has implemented the ‘personal best’ initiative whereby staff are encouraged to enhance the lives of residents. Seventy-five per cent of staff have completed their ‘personal best’ with three staff who have achieved ‘legend’. Thank you notes reviewed from residents identified improvements made to their daily life, as a result of the ‘personal best’ initiative. Bethesda 2014 goals were partially achieved; therefore they carried them over to 2015 with further strategies. Quarterly progress report reviewed identified YTD that they have reduced facility acquired pressure injuries by 10% (Bethesda had the 10th equal highest rate of pressure injuries in

		its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia, (eg, mortality and pressure incidence rates and staff accident and injury rates). Benchmarking of some key indicators with another NZ provider is also in place. Bethesda is proactive in implementing and evaluating their quality goals. Strategies are also in place around implementation of the organisational goals, (i) B Fit programme to support health and wellbeing of our people, and (ii) manual handling.	the Bupa hospital benchmarking group in 2014 – YTD is 1.1). The service implemented the following strategies that included (but not limited to): (i) Analysis of pressure area data from 2014, to identify root cause: (ii) Workshop for RNs on pressure area risk assessments: (iii) Compulsory in-service on pressure area management and hydration and nutrition: (iv) Commencing turn charts and nutrition charts early, for those identified at risk and (v) review of equipment. Another quality goal includes reducing the number of eye infections in the rest home wing by 10% (link 1.2.3.6). The other goal around reducing the number of acquired skin tears in the hospital wing by 10% is still an ongoing issue, however documentation reviewed identified the service continues to evaluate this and ensures the effectiveness of strategies is re-evaluated and new actions/strategies are implemented. Regular 'tool box' talks are held with staff.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality action	Bethesda is active in analysing data collected monthly around accidents and incidents, infection control, restraint etc. Example: In July 2015, statistics showed that they were above the organisational benchmark for falls in both the rest home and hospital. This was shared with the nursing and care staff and suggested actions to address the issue were discussed. As part of their corrective actions, they started a falls focus committee. A group analyses the incidents further, to assist in identifying any trends and looks at additional activities that would focus on these trends and reduce their rate of falls by 30%. Following the first meeting, they sourced and then distributed falls preventative information via the residents' newsletter, and displayed this information on the residents' noticeboards as a point of focus. Graphs showing their trends were also displayed on the residents' noticeboards and published in the newsletter. Additional education for staff around moving and handling training was provided at three different times throughout one day, in order to capture

		forms are utilised at Bethesda and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Bethesda is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified	as many of the qualified nurses and caregiving staff as possible. Education sessions via toolbox talks were delivered by RNs to care staff during handovers. This information covered fluid intake, and for residents to be invited to join exercise class in the facility. The GP was spoken to about all residents who were assessed as high risk and prescriptions for Vitamin D supplements were completed. On evaluation of the effectiveness of these measures, they noted a drop in falls incidents in the rest home in August from 16 down to four (75%). These findings were discussed at the upcoming clinical and quality meetings and monthly residents' newsletters.
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	CI	The service plans and operational structures combine to provide a comprehensive quality development and risk management system. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Bethesda to document actions that have improved or enhanced a current process or system or actions, which have improved	Audit results 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, (eg, quality meeting, resident and staff meeting). Bethesda has monthly quality and risk management meetings and this includes progress toward meeting their annual quality goals. The quality goals identified annually at Bethesda includes documented quarterly progress and evaluation. Progress is forwarded to the quality management coordinator for Bupa. The service completed regular progress reporting and implemented ongoing corrective action plans to meet their 2014 goals. Example: In 2014, they were above the organisational benchmark for acquired eye infections in the rest home. One of their goals for 2014 was to decrease the numbers of infections in the rest home by 10%. Posters and toolbox talks were used to highlight the five moments of hand hygiene for all staff. Reminders and education for staff has been

		outcomes or efficiencies in the facility. Audit results 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, for example, the quality meeting and through newsletters. The facility manager provides a documented weekly report to the Bupa operations manager. The operations manager visits as required and completes a report to the general manager, care homes.	provided regarding the appropriate use of gloves. Regular three monthly infection control audits by infection control coordinator and unit coordinators. At the review of the quality goals from 2014, unfortunately this goal was not achieved in the rest home and so was carried over into 2015. It was achieved in the hospital wing. The following corrective actions initiated this year: Qualified staff provided education to the care staff on hand hygiene and the use of the appropriate coloured facecloths. Care staff then educated the residents on how to prevent eye infection when doing their cares. On evaluation in August 2015, they have had only three reported, compared to seven.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	A contracted physiotherapist assists with the exercise and walking groups. A physiotherapist assistant assists with walking, mobility and transfer. On the day of audit, residents in all 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. Wi-Fi is available for all	The service identified that their satisfaction survey results were lower this year, in regards to the activity programme. Because of this they were keen to be part of the Bupa Activity Pilot Programme aiming at offering more meaningful activities. This pilot has included increasing hours by 30 hours extra a week. The programme has increased community links, more activities across the weekend, increased one-on-one time, increased variety of programme, increasing van outings, sharing of activity information with other facilities. Exercise class is now seven days per week and approximately 20 residents per day attend. Feedback from residents/relatives is obtained after each activity and evaluated. Residents have more of an input into the activity programme and they assist to develop it through the resident meetings. The six weekly activities planning meeting also ensures activities are integrated with physiotherapy, catering needs etc. Weekly report to manager includes an ongoing evaluation of the programme and feedback from residents. The activity staff attend annual forums through Bupa, the March 2015 forum included the changes with the Introduction of InterRAI. All assessments and activity plans have been updated. The Camellia Lounge/dining room has been refurbished, more activities are now being held there, away from the business of the main lounge and reception. There is a monthly newsletter and activities plan for all residents/relatives.

		residents.	

End of the report.