

# Bupa Care Services NZ Limited - Cornwall Park Hospital

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## Introduction

This report records the results of a Surveillance 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:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Cornwall Park Hospital
<b>Services audited:</b>	Hospital services - Psychogeriatric services
<b>Dates of audit:</b>	Start date: 12 May 2016    End date: 13 May 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	35

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Cornwall Park Hospital is part of the Bupa group. The service is certified to provide hospital services (psychogeriatric level care) for up to 39 residents. On the day of the audit, there were 35 residents.

This unannounced surveillance audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

A care home manager (non-clinical) who is new to the role currently manages the service. The regional operations manager and a clinical manager, who is also new to the role, support the care home manager. A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care and support.

Twelve of fifteen shortfalls from the previous audit have been addressed. These were around incident/accident documentation, staff performance issues, care plan timeframes, registered nurse follow-up, medication documentation, chemical management, maintenance, locked exit doors, cleaning, restraint management and outbreak documentation. Further improvements are required around communication of quality activities, implementation of monitoring and updating care plans.

This audit has identified that improvements are required in relation to corrective action plans.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Families interviewed report that they are kept informed. Family/whānau and/or EPOAs are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned 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. Quality and risk management processes are directed by policy and procedure. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An 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. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The clinical manager takes primary responsibility for managing entry to the service, with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the InterRAI outcomes and other assessments. They are clearly written and healthcare assistants report they are easy to follow. Families interviewed confirmed they were involved in the care planning and review process.

An activities coordinator facilitates the activities programme. Families report satisfaction with the activities programme. The programme is appropriate to resident cognitive and physical abilities.

Medication polices comply with legislation and guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Meals are prepared on site and the menu is varied and appropriate. Individual and special dietary needs are catered for. Families interviewed were complimentary about the food service.

## Safe and appropriate environment

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

## 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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service has five residents using restraint and no residents using an enabler.

## 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.
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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	2	1	0	0
<b>Criteria</b>	0	40	0	3	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The care home manager manages complaints received. The previous six months of complaint records were reviewed and there was a complaint management record completed for each complaint. All complaints had been investigated with appropriate documentation on record. A record of complaints each month is maintained by the facility on the complaint register. The number of complaints received each month is included in the Bupa benchmarking programme. Interview with relatives confirm they were provided with information on complaints and that a complaints procedure is provided to residents/family whānau within the information pack at entry, and is also around the facility on noticeboards.</p> <p>All complaints received in the past six months are resolved, including a complaint received via the Health and Disability Commissioner in August 2015. The service has implemented the corrective actions required. The revised Bupa complaints policy was sighted, the local nursing strategy has been implemented which resulted in the appointment of a non-clinical care home manager and a clinical manager, and tracking and clinical supervision for the registered nurses involved in the complaint. Management advised that the complaint is now closed (Health and Disability letter confirmation sighted).</p> <p>The Ministry requested follow-up against aspects of the HDC complaint that included communication, complaints management, quality and risk management systems, human resource management, service provider availability, service provision requirements, service delivery, and evaluations. This audit has identified issues with the quality and risk management systems (link 1.2.3.6, 1.2.3.8, and 1.2.3.9) and service delivery (link 1.3.6.1). There were no</p>



		other identified issues in respect of the complaint in the standards reviewed.
<p>Standard 1.1.9: Communication</p> <p>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 in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Accident/incident forms have a section to indicate if family/whānau have been informed (or not) of an accident/incident. A review of 10 incident forms met this requirement. Seven family members interviewed confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available.</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>	FA	<p>Cornwall Park provides specialist hospital level care (psychogeriatric) for up to 38 residents and is part of the Bupa group. On the day of the audit there were 35 residents including one resident at hospital level care. This resident has been at Cornwall Park for a number of years and has been reassessed as hospital (geriatric) level of care (link 2.2.3)</p> <p>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.</p> <p>The care home manager provides a documented weekly report to the Bupa Operations Manager. The operations manager visits regularly and completes a report to the Director Care Homes/Rehabilitation. Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services.</p> <p>The service is managed by a care home manager (non-clinical) who has had been in the role for three months. The care home manager was previously the administration manager at Cornwell Park, and had been in that role for 10 years. The care home manager is supported by a clinical manager (CM) who had been in the role for one week at the time of the audit. The clinical manager has had previous experience as a clinical leader and has worked as an RN at Cornwall Park for the previous 12 months. Staff spoke positively about the support/direction and management of the current management team.</p> <p>Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly.</p>
Standard 1.2.3:	PA	Quality and risk management systems are in place. Interviews with staff (eight caregivers, six registered nurses, a

<p>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>	<p>Moderate</p>	<p>cook, and an activities coordinator) confirmed their understanding of the quality and risk management programmes.</p> <p>There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.</p> <p>The quality and risk management programmes includes an internal audit programme and data collection, analyses and review of adverse events including accidents, incidents, infections, wounds and pressure areas. Corrective actions were not always documented where shortfalls had been identified in quality data collected. Benchmarking data and corrective actions were not always documented as discussed at quality or staff meetings and the meeting schedule had not always been followed. Restraint incidents are discussed at restraint meetings. However, the overall previous finding related to discussion of clinical indicator data and corrective actions at staff meetings remains open.</p> <p>The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored. The outdoor garden has been modified since the last audit and the previous hazards in the outdoor garden area have been eliminated. The service has a current hazard register. A system has been put in place to review T belt buckles monthly, to ensure they are fit for purpose and not showing any sign of wear or malfunction and this is an improvement on previous audit.</p> <p>Falls prevention strategies are in place including the analyses of falls and the identification of interventions on a case-by-case basis to minimise future falls. Selected residents wear hip protectors to reduce injury from falls and sensor mats are in place to reduce the number of falls.</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</p>	<p>FA</p>	<p>Incident and accident data is collected and analysed and benchmarked through the Bupa benchmarking programme. A sample of ten resident related incident reports were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided and documented following an incident. Reports were fully completed and follow-up, referrals and investigations have been conducted as required. The previous audit finding related to the completion of the incident form, documentation in the care plan and corrective actions has now been addressed.</p> <p>All incidents and accident data has been communicated to staff, as evidenced in meeting minutes reviewed and staff interviewed. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Family interviewed confirmed they were advised of any incident or accident involving their family member.</p>

of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Organisational policies guide recruitment practices and there are documented job descriptions for all positions. Appropriate recruitment documentation was seen in the seven staff files reviewed (one clinical manager, two registered nurses, two caregivers, one cook and one activities coordinator). A register of practising certificates is maintained. Performance appraisals were current in all files reviewed. Appropriate follow-up in regards to complaints about staff performance was evidenced. The previous audit finding related to follow-up of performance/complaints has been addressed. The care home manager advised that the caregiver workforce is stable. Interviews with caregivers informed that management are supportive and responsive.</p> <p>There is an annual education schedule that is being implemented and an RN/EN training day provided through Bupa that covers clinical aspects of care. A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained. Staff interviewed were aware of the requirement to complete competency training. There is a staff member with a current first aid certificate on every shift.</p> <p>There are 23 caregivers, 18 have completed the required dementia standards and five are currently in the process. The five caregivers currently completing the unit standards have been employed in the last 12 months.</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>	FA	<p>An organisational staffing policy aligns with contractual requirements and includes skill mixes. The WAS (Wage Analysis Schedule) is based on the Safe Indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A fortnightly report from head office includes hours, and whether the hours are over and above. There is at least one RN and first aid trained member of staff on every shift. Interviews with staff and relatives inform there are sufficient staff to meet the care needs of the residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	FA	<p>Twelve medication charts were reviewed. There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication system. All medication charts sampled met legislative prescribing requirements and identified indications for use for as required medication.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role about medicine administration.</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>Standing orders are not used and no residents are self-medicating.</p> <p>Medication charts reviewed identified that the GP had seen resident's medication at least three monthly. The service monitors and evaluates residents on antipsychotic medication monthly as evidenced in the five medication charts sampled for residents using antipsychotic medications.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges. If the fridge temperature were outside of the acceptable range corrective actions were promptly implemented.</p> <p>The previous audit findings related to the prescribing of 'as required' medication and the review of residents using antipsychotic medications has been met.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Bupa Cornwall are prepared and cooked on site. There is a four weekly summer and winter menu with dietitian review and audit of menus. Meals are prepared in a kitchen adjacent to the main dining room for serving. The cook and kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for, to promote independence. Food services staff know resident dietary profiles and likes and dislikes and any changes are communicated to the kitchen via the registered nurses. A dietitian is available via referral to review residents. Supplements and fortified foods are provided to residents with identified weight loss issues. The cook was fully aware of residents with weight loss issues and all residents' food preferences. Family meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service. There is evidence that there are additional nutritious snacks available over 24 hours. Caregivers were observed assisting residents with meals during the audit.</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>PA Low</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>In the resident files reviewed, short-term care plans commenced with a change in health condition, and linked to the long-term care plan. Long-term care plans were reviewed six monthly. Interventions were documented for all assessed care needs, however not all monitoring forms were fully completed. The previous audit finding related to interventions remains.</p> <p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure areas. On the day of audit there were ten wounds (all skin tears). There were no pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management,</p>

		<p>and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p> <p>Strategies for the provisions of a low stimulus environment could be described in interviews with staff.</p> <p>The care staff advised they have enough equipment to meet the assessed care needs of the residents.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>	FA	<p>The activities coordinator at Bupa Cornwall provides an activities programme over five days per week. Group activities are voluntary. Residents are able to participate in a range of activities appropriate to their capabilities. Bupa Cornwall shares a van and residents are taken on outings at least weekly. The activities coordinator accompanies the resident on outings. The group activity plans are displayed on noticeboards around the facility. Residents who do not participate regularly in the group activities are visited for one-on-one sessions, with records kept to ensure all such residents are included. All interactions observed on the day of the audit indicated a friendly relationship between residents and the activity coordinator. Each resident has a map of life developed on admission, which forms the basis of the activities plan. The resident files reviewed included a section of the long-term care plan for activities, which has been reviewed six monthly. The care plan includes activity over a 24-hour period. The activities coordinator has maintained six monthly reviews. Residents' families interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys.</p> <p>Caregivers were observed various times throughout the day diverting residents from behaviours. Caregivers assist with activities over the weekend and evenings and there is always a caregiver present in the lounge to observe and monitor residents. The programme observed was appropriate for older people with mental health conditions.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a monthly review and three monthly review of the resident's medication by the GP. All changes in health status were documented and followed up. Reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. The RN completing the plan signs care plan reviews. However, not all intervention documented in the care plan evaluations were transferred to the care plan. Where progress is different from expected, the service has not fully responded by initiating changes to the care plan. The previous audit finding related to care plan evaluations remains open.</p>
<p><b>Standard 1.4.1: Management Of Waste And</b></p>	FA	<p>The chemical/substance safety policy guides all staff in the management of all waste and hazardous substances. Management of waste, chemical safety and hazardous substances is covered during orientation of new staff and subsequent training sessions have been held around chemical safety. All chemicals are clearly labelled with</p>

<p>Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>manufacturer's labels. The previous finding related to labelling of chemicals has been met.</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>FA</p>	<p>The service displays a current building warrant of fitness, which expires on 19 October 2016. There is a maintenance person who works 20 hours per week at Bupa Cornwall Park and works at another Bupa Facility. Reactive and preventative maintenance has been documented monthly, since the last audit. Hot water temperatures are checked and records sighted evidence that temperatures are maintained at no more than 45 degrees Celsius. An external provider checks fire equipment. All medical equipment has been calibrated and checked. The previous audit finding related to preventative maintenance and hot water temperature recordings has been met.</p> <p>Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained with gardens and outdoor seating and shade available. The outdoor areas have recently been refurbished and are secure with walking paths. The residents can freely access one of the enclosed garden areas. Two other outdoor areas have locked doors and the residents can only access these areas with supervision. A quiet, low stimulus area provides safety for non-mobile residents when required. This area has a half stable-door with a keypad access code. The staff complete intentional rounding and the residents in the safe zone area are regularly monitored through the open half door. There is wheelchair access to all areas. The previous audit finding related to garden access and garden safety has been addressed.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	<p>FA</p>	<p>There are policies for cleaning and laundry processes. An external contractor completes all laundry. There are daily deliveries of laundry. There are dedicated cleaning staff. The cleaning staff manage the collection of dirty laundry and delivery of clean laundry. All equipment and areas of the facility were clean on the days of audit. Care staff complete two hourly visual checks of the toilets and bathroom areas. The previous audit finding related to cleanliness has been addressed.</p>

appropriate to the setting in which the service is being provided.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly, to identify areas for improvement or corrective action requirements (link 1.2.3.8). Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections in place are appropriate to the complexity of service provided. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks since the previous audit. The infection control coordinator and the clinical manager could describe the process, documentation and evaluation required if an outbreak occurred. The previous audit finding related to infection control has been addressed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>A regional restraint group at an organisation level reviews restraint practices and there are monthly restraint meetings at the facility where all residents using restraint or enablers are reviewed (minutes sighted). There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</p> <p>The process of assessment and evaluation of enabler use is the same as a restraint and is included in the policy. Currently the service has five restraints (including one under environmental restraint) and no enablers in use. A register for each restraint is completed that includes a three-monthly evaluation.</p> <p>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.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>There are approved restraints documented in the policy (bed rails, lap belts, t belts and environmental restraint). The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. One resident (reassessed as hospital level), has been assessed as being on environmental restraint. Interventions are clearly documented.</p> <p>The service has a quiet lounge with a stable door. The lower door could be locked and opened via a key pad. This lounge is off the main lounge. Immobile residents that require a quieter space where they will not be disturbed by wandering and agitated residents use this area in the mornings. Half stable-doors were also in use for immobile</p>

		<p>residents who were resting on their beds. The half bedroom doors were held closed with a gutter bolt and could be freely opened by staff and family visiting.</p> <p>The residents using the quiet lounge when the half stable doors were locked, and the residents resting on their beds behind the closed half stable doors, had strategies documented in their care plan. These strategies described the care and procedures to be implemented whilst the resident was using an area with a locked or closed half door. Staff were observed checking residents in the quiet lounge and residents in their bedrooms, and they could describe how checks at least every 15mins were completed. One caregiver is assigned to oversee both lounges at all times. This aspect of the previous audit finding related to use of the locked and closed half doors has been met.</p> <p>Monitoring is documented and the use of restraint evaluated (link 1.3.6.1).</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Bupa Cornwall Park has an annual meeting schedule. All meetings scheduled on the 2016-2017 schedule up to the day of audit have been held. Quality data is being collected and analysed according to the organisational policies. Corrective actions and quality data was not always being communicated to staff via quality/staff meetings. A number of the scheduled meetings in 2015 were not conducted including: health and safety, infection control, quality, RN and restraint meetings in December; the caregivers' restraint and kitchen/domestic meetings in November; the family forums in May and June; and the caregivers' restraint, registered nurses and activities meetings in May 2015.	i) The 2014-2015 meeting schedule was not fully implemented and not all the required meetings were held. ii) Quality data was not consistently communicated to staff (clinical indicator data and internal audit outcomes).	(i) Ensure the meeting schedule is fully implemented. ii) Ensure that quality data and outcomes are communicated to staff.  60 days
Criterion 1.2.3.8	PA Low	Where quality indicator data does not meet the company benchmark, there were examples of where a corrective action plan had been developed and	Where shortfalls were identified in internal	Ensure that corrective

<p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>		<p>implemented. However, not all areas identified through the quality management system as needing improvements, had corrective action plans documented and implemented.</p>	<p>audits completed, and clinical indicator data was above the company benchmark, corrective actions were not consistently documented.</p>	<p>action plans are documented and implemented for all areas requiring improvements.</p> <p>90 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>There are restraint care plans in place, which document the required monitoring whilst the resident is using the restraint. Two of three residents with restraint have had restraint monitoring consistently documented when in use.</p>	<p>One of three residents using restraint did not have the required monitoring consistently documented.</p>	<p>Ensure that the required monitoring for residents using a restraint is consistently documented.</p> <p>60 days</p>
<p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Low</p>	<p>The care plans reviewed were evaluated within the required timeframes or with a change in health condition. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Two of five long-term resident files and care plans reviewed had the six monthly evaluations transferred to the care plan.</p>	<p>Three of five long-term resident files reviewed had interventions noted in the evaluations and these were not updated to the long-term care plan.</p>	<p>Ensure that all interventions noted in the care plan evaluation are transferred to the care plan.</p> <p>60 days</p>

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

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

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

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

No data to display
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End of the report.