

Bupa Care Services NZ Limited - Cornwall Park Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Bupa Care Services NZ Limited

Premises audited: Cornwall Park Hospital

Services audited: Hospital services - Psychogeriatric services

Dates of audit: Start date: 23 May 2017 End date: 24 May 2017

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: 36

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bupa Cornwall provides psychogeriatric level care for up to 39 residents. During the audit, there were 36 residents.

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

The care home manager has been in the role for one year and is supported by a clinical manager (registered nurse), the Bupa regional operations manager and quality and risk team.

This certification audit identified that improvements are required around education and care planning.

A continuous improvement has been achieved around the quality programme.

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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Staff endeavour to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Code of Health and Disability Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with the resident's representative. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The care home manager has been in the role for one year. She is supported by a clinical manager, registered nurses, caregivers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Family forum meetings are held and families complete an annual satisfaction survey. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. An education and training programme is established with a

current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate cover for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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A comprehensive information booklet is available for residents/families at entry which includes information on the service philosophy, services provided and practices relevant to a psychogeriatric secure unit. The care home manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed were based on the interRAI outcomes and other assessments. They were clearly written and caregivers report they are easy to follow. Families interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community team as required.

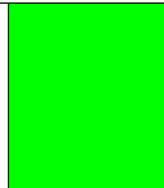
There is a group activity programme. Individual activity plans have also been developed in consultation with family. The activity programme includes meaningful activities that meet the recreational needs and preferences of the psychogeriatric residents.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. There are regular visits and support provided by the community mental health team and psychogeriatrician.

All meals are prepared on-site. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period.

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.

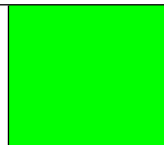
The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services. Laundry is completed off-site at another Bupa facility.

There are shared and single rooms within the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe, easily accessible and secure.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is a staff member on duty on each shift that holds a current first aid certificate.

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.

Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. On the day of audit there were five residents using restraint and no residents with an enabler. Restraint management processes are being implemented.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer 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	0	48	0	2	0	0	0
Criteria	1	98	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (the care home manager, clinical manager/RN, four caregivers, four registered nurses (RNs), one cleaner, one maintenance person and one activity coordinator) confirmed their familiarity with the Code. Interviews with five relatives confirmed that the services being provided are in line with the Code. The Code is discussed at family forum and staff meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents obtained on admission are included in residents' files. Advance directives, if known, are on the residents' files. There is evidence of GP and family discussion regarding a clinically not indicated resuscitation status. Copies of enduring power of attorney (EPOA) are in resident files.</p> <p>An informed consent policy is implemented. Systems are in place to ensure family/whānau/EPOA are provided with appropriate information to make informed choices and informed decisions. Family members interviewed confirm they have been made aware of and fully understand informed consent processes and confirm that appropriate information had been provided.</p> <p>Resident's files reviewed have a signed admission agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There is a policy that describes the role of advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer and includes advocacy contact details. The information pack provided to family/whānau/EPOA at the time of entry to the service provides family with advocacy information. Advocacy support is available.</p> <p>Interviews with staff and relatives confirms that they are aware of advocacy services and how to access an advocate. The complaints process includes informing the complainant of their right to contact an advocacy service for support.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The activity programme contains links to the local community including: local churches; volunteers; nearby schools; entertainers; and cultural groups. Interview with staff and families confirms that residents are supported as able to maintain their previous interests. Visiting can occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. There is complaint forms available. Information about complaints is provided on admission. A suggestions box is held at reception. Interviews with residents and families demonstrates their understanding of the complaints process. All staff are able to describe the process around reporting complaints.</p> <p>A complaints register is being maintained. Five complaints were lodged in 2016, which include both verbal and written complaints. All complaints held in the register include evidence of an investigation, corrective actions (where indicated) and resolutions. One complaint lodged with Auckland District Health Board (ADHB) in 2017 has been signed off as resolved (letter from ADHB sighted).</p> <p>Complaints are linked to the quality and risk management system. Discussions with relatives confirms that issues are addressed promptly and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters displaying the Code. The service is able to provide information in different languages and/or in large print if requested. On entry to the service the care home manager or clinical manager discuss the Code with family/whānau/EPOA. Information relating to the Code is given in the information pack to the next of kin or enduring power of attorney (EPOA) to read and discuss. Family forum meetings are held three times a year and provide relatives an opportunity to discuss any concerns.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. Individual preferences are identified during the admission and care planning process with family involvement. The service has fifteen shared rooms and also single rooms. All shared rooms have privacy curtains. Family are advised in the information brochure that the facility has mostly shared rooms and are informed as to current room vacancies and are able to choose a room/bed when completing a tour of the facility. The admission agreement contains information as to the sharing of rooms. During the audit, staff demonstrated gaining permission prior to entering residents' rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' cares. The service encourages residents to have choice where able, such as voluntary participation in daily activities.</p> <p>Family members interviewed confirm that staff promote the residents' independence wherever possible and that residents' choices are encouraged. There is an implemented abuse and neglect policy.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established Māori cultural policies to help meet the cultural needs of its Māori residents. Bupa has developed Māori Tikanga best practice guidelines. The service has established links with a local Māori advisor. Staff training includes cultural safety. A cultural assessment is completed during the resident's entry to the service. There is one resident who identifies as Māori. Cultural needs are identified in the resident's care plan (sighted).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping to meet the cultural needs of the residents. Relatives interviewed report that they are satisfied that the residents' cultural and individual values are being met. Information gathered during assessment including residents' cultural, beliefs and values, is used to develop a care plan, which their family/whānau are asked to consult on. Discussions with staff confirms that they are aware of the need to respond to the cultural needs of the residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<p>A staff code of conduct is discussed during the new employee's orientation to the service and is signed by the new employee (sighted in all seven employees' files audited). Professional boundaries are defined in job descriptions. Interviews with staff confirms their understanding of professional boundaries</p>

harassment, sexual, financial, or other exploitation.		including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Evidence-based practice was evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, twenty four hours a day. The service receives support from the District Health Board which includes visits from specialists (e.g., wound care and mental health), staff education and training. A contracted GP visits the service twice-weekly and provides after hours on-call cover. A psychogeriatrician visits the facility six-weekly and as required. Physiotherapy services are provided for five hours per week. There is an education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community which includes (but is not limited to) advocacy and entertainers.</p> <p>Bupa has a "personal best" initiative, where staff undertake a project to benefit or enhance the life of a resident(s). Of the 23 care staff, 100% have achieved bronze, 71% silver and 60% have achieved gold.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Family members interviewed stated they were provided with information about the service prior to their relative being admitted to the facility. As the facility has mostly shared rooms, the admission brochure and admission agreement contain information related to the sharing of rooms. Accident/incidents, complaints procedures and the policy and process around open disclosure, alert staff of their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.</p> <p>Fifteen incidents/accidents forms selected for review indicated that family have been informed. Family communication sheets are also held in residents' files. Family members interviewed confirmed they are notified of any changes in their family member's health status. Multidisciplinary review meetings (MDR) are documented as occurring six-monthly in resident files reviewed. Family are invited to attend the MDR meetings and if unable to attend, are contacted by the clinical manager and informed of the outcome by telephone or email.</p> <p>Interpreter services are available if needed. There are a number of residents (and staff) from a variety of cultures and caregivers described how they are able to communicate with residents where English is a second language.</p>
Standard 1.2.1: Governance	FA	Bupa Cornwall provides psychogeriatric level care for up to 39 residents. There were 36 residents in the

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>facility on the day of audit. All residents were under the Specialist hospitals contract (ARHSS).</p> <p>There is an overarching Bupa business plan and risk management plan. Additionally, Bupa Cornwall has developed annual quality and health and safety goals. Goals are reviewed regularly in the quality meetings and are updated on the goal sheet quarterly (at a minimum).</p> <p>The service is managed by a care home manager (non-clinical) who has had been in the role for one year. The care home manager is supported by a clinical manager (RN) who oversees clinical care. The clinical manager has been in the role for one year. The management team is supported by the wider Bupa management team including a regional operations manager.</p> <p>Staff and family interviewed praised the management team and spoke highly of the leadership and guidance that is provided to staff and support to family members.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the care home manager, the clinical manager is in charge. For extended absences, a Bupa relieving care home manager is rostered.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the managers and staff (four caregivers, four RNs, activity coordinator, maintenance staff and kitchen manager) confirms their understanding of the quality and risk management systems.</p> <p>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 - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes.</p> <p>An internal audit programme is in place. In addition to scheduled monthly internal audits, a facility health</p>

		<p>check is conducted six-monthly by an external Bupa representative. Data collected (e.g., falls, medication errors, wounds, skin tears, pressure injuries, complaints and challenging behaviours) are collated and analysed for each resident involved. Quality data and results are documented in the quality meetings and communicated to staff in staff meetings. Corrective actions are implemented where opportunities for improvements are identified (e.g., benchmarked data exceeds acceptable limits). Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The care home manager is the health and safety officer. Eight health and safety representatives (interviewed) are either appointed or elected by staff and meet quarterly. Staff undergo annual health and safety training which begins during their orientation. Staff are encouraged to enrol in the 'Bupa Bfit' staff health and safety programme. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed.</p> <p>Strategies are implemented to reduce the number of falls. This includes (but is not limited to): the use of sensor mat, residents at risk wearing hip protectors, regularly checking residents at risk of falling, encouraging participation in activities, and physiotherapy input. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirms that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all fifteen accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow up of residents is conducted by a RN. Unwitnessed falls include neurological observations.</p> <p>Discussion with the care home manager confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	PA Low	<p>There are human resources management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are retained. Seven staff files reviewed (three caregivers, two RNs, one kitchen manager and one activity assistant) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>descriptions. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Caregivers complete an aged care education programme as part of their induction, which meets the New Zealand Quality Authority (NZQSA) requirements.</p> <p>The education programme being implemented includes in-service training, competency assessments, impromptu toolbox talks and study days.</p> <p>The kitchen manager has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on-site. Chemical safety training is included in staff orientation and as a regular in-service topic.</p> <p>RNs are in the process of completing their professional development recognition portfolio (PDRP). Four RNs have completed interRAI training. The care home manager, clinical manager and staff attend external training including sessions provided by the District Health Board.</p> <p>There are 23 caregivers working in the facility; eighteen have completed the required dementia standards and five are currently in the process. Two caregivers currently completing the unit standards have been employed for over twelve 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>	<p>FA</p>	<p>A staff rationale and skill mix policy is in place. Staff rostered on to manage the care requirements of the resident meet contractual requirements. Both the care home manager and clinical manager work full-time Monday-Friday.</p> <p>There are two registered nurses (RNs) rostered on duty on the morning and afternoon shifts, seven days per week. There is one RN rostered on night duty, seven nights per week.</p> <p>The RNs on the morning and afternoon shifts are supported by six caregivers who work 0700-1500 hours and four caregivers on the afternoon shift who work 1500- 2300 hours.</p> <p>The RN on night duty is supported by two caregivers who work 2300-0700 hours.</p> <p>RN staffing meets contractual requirements for psychogeriatric levels of care. The clinical manager along with the care home manager provide after hours on-call cover.</p> <p>Interviews with staff and family members identifies that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>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. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are stored on the electronic medication management system.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has a comprehensive admission and assessment policy and resident's needs are assessed prior to entry. The information pack includes: service philosophy restraint minimisation, behaviour management and the complaint management policy and well as the Code. Information gathered at admission is retained in resident's records. Five relatives interviewed stated they were well informed upon admission.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Fourteen 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 and all medication charts sampled meet legislative prescribing requirements. The medication charts reviewed identify that the GP has seen and reviewed the resident three-monthly.</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. RNs interviewed described their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>The GP reviews the use of anti-psychotic medication and if required makes a referral to the psychogeriatrician.</p> <p>Standing orders are not in use. There are no residents self-medicating.</p>

		The medication fridge temperatures are recorded regularly and these are within acceptable ranges.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Bupa Cornwall are prepared and cooked on-site. There is a four-weekly seasonal menu with dietitian review and audit of menus. The menu is adapted to ensure resident's food preferences are considered. Finger foods and snacks are available for residents over a 24-hour period. 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. Adapted cutlery, sipper cups and lipped plates are available for resident use. Dietary profiles are completed on admission and likes and dislikes and any changes to dietary needs are communicated to the kitchen via the RNs. A dietitian is available on request. Supplements and fortified foods are provided to residents with identified weight loss issues. The kitchen manager (interviewed) is familiar with all residents' likes and dislikes and also those residents with specific dietary needs.</p> <p>Relatives reported on interview, that there are always snacks, fruit and sandwiches available for residents to eat and that these platters are replenished every two hours by care staff with supplies in the kitchen. Relatives also report that meals are well presented and that staff assist those residents who require help with food and fluid intake.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Personal needs information is gathered during admission and needs, outcomes and goals of consumers are identified. All new residents are commenced on behaviour monitoring for the first six weeks post admission. The community mental health team are involved as required during this time. An initial support plan has been completed within 24 hours. Continuing needs/risk assessments are carried out by RNs as indicated.</p> <p>All seven files sampled contain assessments and support plans which are comprehensive and include input from allied health. The activities coordinator completes a comprehensive social assessment that includes identifying diversional, motivation and recreational requirements. A comprehensive 24-hour</p>

		activity care plan is developed in consultation with the resident/family. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The outcomes of interRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process.</p> <p>Four of seven care plans sampled document interventions to meet the residents assessed care needs, identified current abilities, level of independence and specific behavioural management strategies. Behaviour monitoring charts are in use, as appropriate for escalation in behaviours. Care plans demonstrate allied health input into the resident's care and well-being. Family members interviewed confirm they are involved in the care planning process. Staff interviewed report that they find the plans easy to follow.</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>	FA	<p>Residents' care plans are completed by the RNs. When a resident's condition alters, the RN initiates a review and if required, GP or mental health services 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 medication. Discussions with families are documented on the family contact form in the resident file.</p> <p>In the residents' files reviewed, short-term care plans have been commenced with a change in health condition and linked to the long-term care plan. Long-term care plans have been reviewed at least six-monthly. Challenging behaviour assessments are documented with amendments made to the care plan as required.</p> <p>There is regular input into the resident's care from the visiting community mental health specialist nurses and the psychogeriatrician. There is evidence in the medical notes of GP communication with the psychogeriatrician in regard to medication review.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and the continence products that are required are identified.</p> <p>Adequate dressing supplies are available. Wound management policies and procedures are in place and weights are recorded at least monthly.</p> <p>The clinical manager and RNs (interviewed) described the referral process should they require</p>

		<p>assistance from the mental health services, wound specialist, continence nurse, dietitian, speech language therapist, diabetes nurse or other allied health or nursing specialists.</p> <p>There is a comprehensive range of monitoring forms available for use and these have been completed as needed.</p> <p>The care team and activities staff interviewed are able describe strategies for the provision of a low stimulus environment.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities coordinator is new to the role (six months), she was in the activities support role for six months prior to commencing the coordinator role. The activities coordinator has received training around dementia care and needs. Bupa Cornwall contract a van and driver for weekly van trips. The activities coordinator and/or volunteers accompanies the residents on outings.</p> <p>The weekly activities programmes are displayed around the facility on noticeboards. Residents who do not participate regularly in the group activities, are visited for one-on-one sessions. 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; this includes previous careers, hobbies and life accomplishments and interests 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 which can be used to minimise, distract or de-escalate behaviours.</p> <p>Relatives interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings. Feedback from the March 2017 family forum meeting minutes' documents there is overall a more settled atmosphere amongst residents participating in activities and fewer episodes of challenging behaviours reported or observed by family members who visit daily at varying times (link to 1.2.3.6).</p> <p>Caregivers assist with activities over the weekend and evenings and there is a caregiver allocated on each shift to be in the lounge to observe and monitor residents. Care staff were observed at various times through the day diverting residents from challenging or agitated behaviours.</p> <p>Cultural awareness in activities is noted with the introduction of a Kapa Haka group and the Chinese community who visit the facility regularly. A selection of interactive games is set up for residents to choose which they prefer at the time.</p>
<p>Standard 1.3.8: Evaluation</p>	FA	<p>In the residents' files reviewed, all initial care plans have been documented and evaluated by the RN</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Evaluation includes documenting progress towards the achievement of the intended goals. The multidisciplinary review involves the RN, GP, community mental health team (as required), activities staff and 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.</p> <p>Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care are discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Gloves, aprons, face shields and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets are available. 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.</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>A current building warrant of fitness certificate is posted at the entrance to the facility (expires 19 October 2017). The maintenance person works 20 hours per week and is available on call after hours if needed. A 52-week planned maintenance schedule is in place that has been maintained.</p> <p>All medical equipment has been calibrated and checked. Hot water temperatures are checked in each of the wings and records sighted evidence that temperatures are maintained at no more than 45 degrees Celsius. All floor areas are vinyl surfaces. The corridors have hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are maintained with gardens and outdoor seating and shade available. The outdoor area is secure with walking paths.</p>

		There is wheelchair access to all areas. Two of the doors to the outdoor area have a coded keypad access. One sliding door provides outdoor access with no coded keypad. The service has a quiet lounge with stable doors. The lower door can be locked. Later in the afternoon immobile residents that require a quieter space are moved into this lounge so as not to be disturbed by wandering and agitated residents. During this time, the lower stable door is locked and top half of the door is open so residents can be sighted easily. One caregiver is assigned to oversee both lounges at all times.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All single and shared rooms have wash hand basin facilities. There are sufficient toilets and communal showers for the residents within the facility. There are also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and privacy locks. Paper hand towel dispensers and flowing soap are available for use in all toilet areas. All shared rooms have privacy curtains.
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	Shared and single rooms are available. Residents are encouraged to personalise their bedrooms as desired. The resident rooms are spacious and it can be demonstrated that wheelchairs, hoists and the like can be manoeuvred around the bed and personal space. Staff report that rooms have sufficient room to allow cares to take place. Staff were observed on the days of audit using equipment in resident's rooms and throughout the facility.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Residents are able to move freely and furniture is well arranged to facilitate this. Seating and space is arranged to allow both individual and group activities to occur. Activities occur in the lounge, dining area or outside courtyards. There is a family/whānau room. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were observed on the days of audit freely moving around the facility and staff assisting them if required. There are smaller seating areas and destination points available, including a grocery store and café/bar area. The lounge and dining room are accessible and can accommodate the equipment required for the residents. Residents were observed mobilising freely around the unit.

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies for cleaning and laundry processes. All laundry is completed off-site at another Bupa facility. There are daily pickups of dirty laundry and delivery of clean laundry. There is an area designated for storage of dirty laundry until pick up and a clean area for delivery. Laundry and cleaning audits are completed as part of the internal audit programme.</p> <p>There are dedicated cleaning staff. Care staff complete two-hourly visual checks of the toilets and bathroom areas. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Cleaning trolleys are well equipped and stored safely when not in use. Relatives interviewed report that they were satisfied with the laundry and cleaning services provided.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff with ongoing in-service training. Fire training occurred in September 2016. A fire drill was carried out in March 2017. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, medical supplies and gas for cooking. Short-term back up power for emergency lighting and call bells is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The activity coordinator who goes on outings with residents is also trained in first aid procedures.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Sensor mats were evidenced in use to alert staff that a resident may be attempting to mobilise unaided. Security systems are in place to ensure residents are safe. There are surveillance cameras in the corridors. Security checks are conducted by evening staff and a contracted security company.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility has appropriate heating which can be controlled in each area. Heat pumps/air conditioners are installed in communal areas. All communal rooms and bedrooms are well ventilated and light. Residents and family report that the temperature of the facility is comfortable.</p>
<p>Standard 3.1: Infection control</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and infection control programme description is available. The</p>

<p>management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>infection control officer is an RN. There is a job description for the infection control (IC) officer and clearly defined guidelines. The infection control programme is linked into the quality management programme. The Infection Control Committee meets monthly. The quality meetings reviewed also include a discussion of infection control matters. The IC programme is reviewed annually at head office. Annual quality and infection control goals are set at the beginning of the year. The facility has developed links with the GP's, local laboratory and the infection control and public health departments at the local DHB.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Bupa Cornwall Park. The infection control (IC) officer has completed external infection control education. The infection control team is representative of the facility. They meet to discuss infection rates, education and internal audit outcomes. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.</p> <p>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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides</p>	<p>FA</p>	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control officer supported by the clinical manager who have both completed training to ensure knowledge of current practice. All infection control training has been documented and a record of</p>

<p>relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infections are included on a monthly register and a monthly report is completed by the infection control officer. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly. Meeting minutes are made available to staff. Benchmarking occurs against other Bupa facilities.</p> <p>Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Infection control data is collated monthly and discussed at the staff meetings. The infection control programme is linked with the quality management programme.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and geriatrician that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks reported since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a regional restraint group at an organisation level, which reviews restraint practices. The quality committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures. There are five residents requiring the use of a restraint and there are no residents requiring the use of an enabler. All restraint use is recorded on a restraint register. Files for five residents with restraint were reviewed. All files evidence that a documented three-monthly review of restraint has been conducted. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A RN is the restraint coordinator. The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions include the restraint coordinator, clinical manager, RNs, resident or family representative and medical practitioner. Restraint use and review is conducted at restraint meetings and reported to the quality team meeting.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, clinical manager, RNs, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Assessments and consent forms are fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated, justified and approval processes are followed. There is an assessment form/process that has been documented for all restraint files reviewed. The restraint coordinator was interviewed. The five files reviewed have a completed assessment form and a care plan that reflects risk. Monitoring forms are present in the files reviewed. Consent forms detailing the reason and type of restraint are completed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has a documented evaluation of restraint every three months. In the five restraint files reviewed, evaluations have been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at restraint meetings, quality and staff meetings. Evaluation timeframes are determined by risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator and/or clinical manager. The restraint coordinator's monthly reports evidence reporting at the restraint meetings and RN/clinical meetings. Restraint use is also reviewed as part of the quality meeting.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Staff training is provided at least 2x monthly and all core subjects have been covered in the programme in the past two years. Also staff receive extra training via toolbox talks. There are a number of competencies completed by staff. Staff have received education in the management of challenging behaviours however, not all caregivers who work regularly in the facility have completed the required dementia-specific national qualification.</p> <p>All registered nurses hold a champion role in; nutrition & weight, incident reporting, behaviour documents, TPR, Doctors Rounds, short-term care plans, emergency equipment, Wounds and Medication</p>	Two caregivers who work in the facility have not completed the required dementia specific national qualification. Both caregivers have been employed for over one year.	<p>Ensure that all caregivers working in the facility are enrolled and have completed dementia-specific education modules within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required</p>	PA Low	The RNs complete assessments to identify the care needs of the resident and use this information to inform the development of the care plan. Not all care plan interventions for assessed care needs are documented in the long term	Three of seven files sampled did not include interventions or interventions were not	Ensure that clinical risk assessments are completed where indicated and the

<p>support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>care plans in sufficient detail to guide the care staff. There is evidence of the use of short-term care plans and these have signed out or added to the long-term care plan, if not resolved.</p>	<p>documented in sufficient detail to guide the care staff in the management of seizures and diabetic emergencies.</p>	<p>care plan interventions are documented in sufficient detail to guide the care staff.</p> <p>90 days</p>
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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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	<p>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 at the quality committee meeting and an action plan is identified. These have been addressed in meeting minutes sighted. Benchmarking reports are generated throughout the year to review performance over a 12-month period.</p> <p>Quality improvement plans are utilised 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. There is also a number of ongoing quality improvements identified through meeting</p>	<p>Bupa Cornwell is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. The care home manager discusses the data and any identified trends or issues at the quality meetings and staff meetings. Any identified common themes around incidents/infections etc. results in further education and toolbox sessions.</p> <p>a) Due to the high number of resident falls in 2016, the facility implemented a falls prevention programme in May 2016, which focused on identifying strategies for the reduction of resident falls.</p> <p>Strategies include: residents experiencing frequent falls had an increase in monitoring to pre-empt impromptu activity, ensuring good hydration, falls focus group, falls</p>

		<p>minutes and as a result of analysis of quality data collected. Bupa Cornwall is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified.</p>	<p>prevention education for staff through toolbox talks and fall prevention pamphlets/poster presentations throughout the service. Documentation reviewed identifies that strategies have been regularly evaluated. In 2015, the falls rate at its peak was 40 falls per month, this reduced to 25 per month in 2016 and 11 per month to date so far in 2017.</p> <p>b) The service also had a focus on reducing the incidents of challenging behaviour due to episodes of sun downing residents, late afternoon/evening. Residents had been trying to go home and attempting to exit the building via the secure entrance door. Behaviours displayed included: residents gathering at the entrance door, trying to use the door handle to open the door, becoming frustrated and aggressive when they could not exit and staff not being able to easily distract the residents from this behaviour.</p> <p>The service has since removed the door handle to this door. The door has always had a keypad lock in place and the door handle was not necessary to exit the door. The door has been covered with a decal depicting an alpine scene. Since the installation of the decal disguising the exit door, there have been no incidents of behaviours related to trying to exit the facility reported or observed. Clinical indicator data (KPI) evidences a reduction in challenging behaviours related to sun downing from 27 incidents in May 2016 to 6 in March 2017.</p>
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End of the report.