

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

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:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Cashmere View Rest Home and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 May 2017 End date: 30 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:	100



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Cashmere View is a Bupa facility, which provides rest home and hospital- including medical and psychogeriatric level care for up to 103 residents. Occupancy on the day of audit was 100 residents.

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

The facility is managed by an experienced facility manager who is supported by a clinical manager (registered nurse), registered nurses, care staff and Bupa regional manager.

This audit identified that the three previous certification audit findings around complaints, dementia unit standards and hot water temperatures have all been addressed.

The five previous findings related to the partial provisional audit of the new 24-bed psychogeriatric unit have been addressed. These include completing refurbishment, securing the garden and providing an update on the fire evacuation scheme.

This audit identified one improvement required around food storage and adherence to kitchen cleaning schedules.

Continuous improvement ratings have been awarded around quality and infection control.

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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Communication with residents and families is appropriately managed and recorded. Complaints are managed and residents and families are aware of the complaints process.

Residents and relatives interviewed state that the staff and management are approachable and available. Residents' meetings are held monthly, providing an opportunity to feedback on the services. Families interviewed confirmed that they are informed of changes in health status and incidents/accidents. The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Complaints reviewed showed the appropriate acknowledgement, investigation and resolution within the required timeframes. Residents and family members advised that they are aware of the complaints procedure and how to access forms.

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.		Standards applicable to this service fully attained.
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Cashmere View is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular relative newsletters. Quality and risk performance is

reported across the facility meetings and to the organisation's management team. Quality initiatives are implemented which provide evidence of improved services for residents. Cashmere View is benchmarked in three of four of the Bupa benchmarking groups (hospital, rest home and psychogeriatric). There are human resources policies to guide practice and an orientation programme that provides new staff with relevant information for safe work practice. The in-service training programme covers relevant aspects of care. External training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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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Assessments, care plans and reviews are completed by the registered nurses within the required timeframes. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication are prescribed and stored appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Snacks are available in the psychogeriatric units.

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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The service displays a current building warrant of fitness. The new psychogeriatric unit has been completed and commissioned and provides a safe and appropriate environment for people requiring psychogeriatric care.

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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The service has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. No residents had enablers and 13 residents (12 at psychogeriatric level of care had lap-belt restraints and 1 hospital resident had a bed rail).

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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	1	0	0	0
Criteria	2	39	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All care staff interviewed (four PG, four hosp, two hosp/rest home) were able to describe the process around reporting complaints. A complaints register is maintained. Complaints for 2016- 2017 (year to date) were reviewed. Nine complaints were received in 2016 and one in 2017. Verbal and written complaints are documented. All complaints documented in the register include an investigation, meet expected timeframes and corrective actions are put into place where indicated. This previous audit finding has been addressed. Complaints are linked to the quality and risk management system.</p> <p>Discussions with residents (four rest home, two hospital) and relatives (one rest home, two PG and two hospital) confirmed that issues are addressed promptly and that they feel comfortable to bring up any concerns with the managers.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure, alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twenty accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>An introduction to the psychogeriatric unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Cashmere View is a Bupa facility. The service provides rest home and hospital- including medical and psychogeriatric level care for up to 103 residents. Occupancy on the day of audit was 100 residents. There were 43 psychogeriatric residents- 20/20 in Barrington psychogeriatric unit and 23/24 in Palmside psychogeriatric unit. There were 46 hospital residents; 30/30 in Pioneer unit and 16 hospital residents and 11 rest home residents in the Ashgrove unit, which is a 29-bed unit approved for dual purpose beds. There was one hospital resident under the medical contract.</p> <p>The Bupa organisation has documented vision and values statements that are shared with staff and are displayed. There is an overall Bupa strategic plan and risk management plan. Additionally, Cashmere View has specific annual quality goals identified that link to the strategic plan and are reviewed quarterly.</p> <p>The care home manager at Cashmere View is an experienced manager (non-clinical) and has an aged residential care background. The care home manager is supported by a clinical manager (registered nurse) who oversees clinical care. The clinical manager has many years of experience working in management roles within aged care facilities. The management team is supported by the wider Bupa management team, which includes an operations manager (interviewed). Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six-monthly. The manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the Bupa regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it 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. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls; infection rates; complaints received; restraint use; pressure areas; wounds; and medication errors. Quality and risk data, including trends in data and benchmarked results, are discussed in the quality and applicable staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed.</p> <p>Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the Health and Safety Committee. Nine health and safety representatives were interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. An employee health and safety programme (Bfit) is in place, which is linked to the overarching Bupa National Health and Safety Plan.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes use of mobility aides, sensor mats and chair alarms. Toileting plans, intentional rounding and resident attendance at exercise programmes are examples of strategies being implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a RN. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system.</p> <p>The care home manager and clinical manager are aware of their 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 employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files reviewed (two RNs, seven caregivers and one activities coordinator) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of RN staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction and annually thereafter. Training on managing challenging behaviours in 2016 and it was repeated in 2017.</p> <p>Twenty-nine caregivers are employed to work in the psychogeriatric units, with twenty-six having completed their national dementia qualification. Three caregivers are in the process of completing their qualification and have been employed in the last six months. This previous audit finding has been addressed.</p> <p>RNs are supported to maintain their professional competency. Twenty-two RNs are employed and fourteen have completed their interRAI training. There are implemented competencies for RNs including (but not limited to) medication competencies.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. Families/whānau and residents interviewed stated that they felt there was sufficient staffing.</p> <p>The care home manager and clinical manager work full-time Monday to Friday. There are two unit coordinators; one oversees the two psychogeriatric units and the other the rest home/hospital units.</p> <p>In Palmside psychogeriatric unit (24 beds) and Barrington Psychogeriatric unit (20 beds), there is a RN on duty on the morning and afternoon shifts and one RN on the night shift in each unit. Additionally, the unit coordinator (RN) works 0630-1500 hours, Monday to Friday. The RNs are supported by five caregivers (three in Palmside and two in Barrington) on the morning and the afternoon shift. In the afternoons, there is also an activity assistant on duty in each unit from 1400-2000 hours. On night duty, there is a RN and one caregiver on duty in each unit.</p> <p>In the Pioneer unit (30 hospital beds) and Ashgrove (29 dual purpose rest home/hospital beds), there is a RN on duty in each unit on the morning and afternoon shifts. Additionally, the unit coordinator works 0900-1630 hours, Monday-Friday. The RNs are supported by nine caregivers (five in Pioneer and four in Ashgrove) on the morning shift and by four and three caregivers on the afternoon shifts. At night, there is one RN on duty who covers both Pioneer and Ashgrove units and is supported by three caregivers. One caregiver is based in each unit and the other caregiver floats between the two units as needed.</p>

		Relatives interviewed advised that there is sufficient staff on duty to provide the care and support required.
<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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There is one resident self-administering medications and a self-medication assessment, consent and reviews have been completed. The service has recently implemented an electronic medication management system (three weeks prior to the audit). An RN checks all medications on delivery against the medication chart and any pharmacy errors recorded are fed back to the supplying pharmacy. Medications are supplied in robotic packs and are appropriately stored in accordance with relevant guidelines and legislation. The medication rooms in all areas are clean, secure and functional. This is an improvement since the previous audit. The medication fridges have temperatures recorded daily and these are within acceptable ranges.</p> <p>All staff who administer medications have been assessed as competent. Annual medication competencies are completed on medication management and administration. Education around safe medication administration has been provided. Staff were observed to be safely administering medications on the days of audit. RNs and care staff interviewed could describe their role regarding medicine administration.</p> <p>Twelve medication charts were reviewed (two rest home and six hospital- including one end of life and four psychogeriatric). The prescribing of medication meets legislative prescribing requirements and administration records documented that medications are administered as prescribed. The medication charts and file notes reviewed identify that the GP has seen and reviewed the resident three-monthly.</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>	PA Low	<p>All meals at Cashmere View are prepared and cooked on-site. There is a four-weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to each unit's dining area. Special dietary needs and food allergies are known with individual likes and dislikes accommodated. The kitchen manager interviewed was aware of the residents with known food allergies and dietary needs. Pureed, gluten free, dairy free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks in the psychogeriatric unit and hospital. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded for each meal. The dishwasher is checked regularly by the chemical supplier. Decanted food was not dated with expiry dates.</p> <p>There is evidence that there are additional nutritious snacks available over 24-hours in all units.</p>

		All food services staff have completed training in food safety and hygiene and chemical safety. Cleaning schedules had not been documented as completed.
<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>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation.</p> <p>The psychogeriatric units have access to support staff at psychiatric services for the elderly. The need for a secure unit has been documented by referring agencies. There is specialist input into resident's well-being in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment were described by the care and activities team. Activities staff are rostered to cover the late afternoon and evening shift. Care staff could describe specific de-escalation techniques and strategies used to address individual resident's behavioural issues. Recent improvements included the addition of a sensory room.</p> <p>Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Four RNs could describe access for wound and continence specialist input as required.</p> <p>Residents and families interviewed reported their needs were being met. Family members interviewed praised the service, the care staff and the management team.</p> <p>One the day of audit, there were 21 wounds documented for the rest home and hospital. The wounds included 13 skin tears, chronic ulcers, skin carcinomas and surgical wounds. GP and wound care specialist input was documented as needed. Care plans reviewed clearly documented skin care, pain management, mobility, pressure relieving strategies and equipment that was in use for each resident.</p> <p>The psychogeriatric units documented 17 wounds (one stage I pressure injury; two unstageable pressure injuries; two wounds due to incontinence; four blisters; two skin tears; skin carcinomas; chronic skin conditions; and one surgical wound). The wound care specialist had reviewed the more serious wounds and wound care plans reflect the specialist input. All wounds sampled had appropriate assessments, management plans and regular reviews.</p> <p>Monitoring charts were in use, examples sighted included (but not limited to): weight and vital signs; blood glucose; pain; food and fluid; turning charts; and behaviour monitoring as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part</p>	FA	<p>The service employs one qualified diversional therapist and seven activities assistants to deliver the activity programme over seven days. The service is overseen by a Bupa occupational therapist who visits the village regularly. Bupa employs a van driver with a current first aid certificate who drives the van for all outings. There is</p>

<p>of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>always at least one staff member with a current first aid certificate that accompanies residents on outings.</p> <p>The programme for rest home and hospital level of care residents takes place in both areas. In the psychogeriatric units, two activity assistants work from 1400-2000 hours (one in each unit). The reduction in challenging behaviours has been attributed to the change in activity coordinator hours in the psychogeriatric units (link to 1.2.3.6). Care staff were observed at various times throughout the day diverting residents from behaviours in the psychogeriatric units. There are 24-hour activity plans documented in the files reviewed for residents in the psychogeriatric units. There are resources available for care staff to use for one-on-one time with the resident. Staff could describe a low stimulus environment.</p> <p>On or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities. The family/resident completes a 'Map of Life' on admission, which includes previous hobbies, community links, family and interests. The individual activity plan is incorporated into the long-term care plan and is reviewed at the same time as the care plan in all resident files reviewed. Activity participation sheets were maintained in files sampled. Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. Families and residents were satisfied with the activities programme provided. Residents from all levels of care were observed to be provided with and enjoying a wide range of activities.</p> <p>There is a range of activities offered that reflect the resident needs and participation is voluntary. The programme includes (but not limited to): walking groups; gardening; pet visits; church services; art and crafts; and music. There are regular entertainers to the home and residents go on regular outings and drives. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. There are resources available for staff to use for one-on-one time with the residents and for group activities. Recent improvements in the psychogeriatric units include a sensory room, large decals covering exit doors, feature walls and several small themed destination seating areas. In the hospital, a large Victorian dolls house was built which residents were able to furnish and decorate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed for long-term residents had been evaluated by RNs six-monthly. There is a comprehensive multidisciplinary review documented. The multidisciplinary review involves the RN, GP, any allied health member involved in individual resident care, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP and psychiatrist visits.</p> <p>Written evaluations described the resident's progress against the residents identified goals. The interRAI assessments have been utilised in conjunction with the six-monthly reviews. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem.</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>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers and toilets to promote safe mobilisation. The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is appropriate and secure, bathroom floors are non-slip and walking areas are not cluttered. The psychogeriatric units have keypad entry and are secure. This previous audit finding has been addressed.</p> <p>The room sizes are adequate and the lounges and dining areas are functional and comfortable for the residents. An appropriate secure outside area is observed with access from the two PG units. All external areas inspected were safe, secure and contain appropriate seating and shade. The security gates attached to the psychogeriatric units were checked. The gates are secure and meet all contractual requirements. The shortfall relating to security identified by the previous audit has been addressed.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tag system shows this has occurred. Clinical equipment is tested and calibrated by an approved provider at least annually or when required. Hot water temperatures are checked regularly and corrective actions implemented when required. This is an improvement since the previous audit. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The current building warrant of fitness expires January 2018.</p> <p>Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>In the Barrington psychogeriatric unit, the lounge and dining area and smaller lounge/seating areas have been completed. Seating and space is arranged to allow both individual and group activities to occur. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. This previous audit finding has been addressed. Communal living areas and the dining rooms across all areas are safe, adequate and utilised by residents.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The fire evacuation scheme was approved in October 2014 and reviewed following changes to the psychogeriatric unit. There was no changes made to the rooms or fire panels and therefore no amendments were required. The previous audit finding has been addressed.</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 coordinator 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 coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality and staff meetings. Benchmarking occurs against other Bupa facilities.</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>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers.</p> <p>At the time of audit there were thirteen residents requiring the use of a restraint (eleven psychogeriatric and one hospital resident). Restraints in use included lap belts and one bedrail. There were no residents using an enabler.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>Food, fluid and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. Temperatures of fridges, freezers and end point cooking are monitored. Food in fridges was dated but decanted dry foods were not. Cleaning schedules have not been maintained.</p>	<p>(i)Expiry dates were not documented on storage containers when food had been decanted from original container. (ii) Cleaning schedules had not been completed as per policy.</p>	<p>(i)Ensure food containers document the expiry date of food. (ii) Ensure cleaning schedules are completed as per policy.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality data is trended and analysed in a comprehensive manner. Staff are kept well-informed regarding results, evidenced in meeting minutes, information posted in the staff room and through interviews with staff. A range of improvements have been identified through quality and risk management processes.</p>	<p>A key indicator of quality of care is the monthly benchmarking data. Quality initiatives are in place to reduce falls and episodes of challenging behaviours. Corrective actions are monitored for effectiveness and re-evaluated. Analysis of benchmarking data reflected an overall falls rate per 1000 occupied bed days that has trended below the benchmark target range of six from October 2016- April 2017 to 5.6. In the psychogeriatric units, episodes of challenging behaviours have also trended below the benchmark rate from October 2016-April 2017.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction</p>	CI	<p>The service has an Infection Control Committee that meets monthly. Surveillance data is reviewed at this meeting and where required, quality improvement plans are developed.</p>	<p>The service implemented a quality improvement based on benchmarking data which evidenced an increase in urinary tract infections in 2015. Improvements implemented included: increasing fluid rounds; offering a variety of fluids; and including smoothies, ice pops and jellies to improve fluid intake. A review of 2016 benchmarking data evidences that urinary tract infections</p>

and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.			have reduced and have remained below the benchmark target rate of 1.15 per 1000 bed nights from January-December 2016.
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End of the report.